State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 3/1/16 through 3/4/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated. The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 26 current Resident reviews (Residents #1- #20, #25-28, and #30-31) and 5 closed record reviews (Residents #21-24 and #29).	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance. **12 VAC 5-371-150 Resident Rights** **12 VAC 5-371-150 (C,D,E) Cross Reference to F-156**	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-150 Resident Rights 12 VAC 5-371-150 (C,D,E) Cross Reference to F-156 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (H) Cross Reference to F-157 12 VAC 5-371-110 Management and administration 12 VAC 5-371-110 (B.2,3,) Cross Reference to F-225 12 VAC 5-371-220 Nursing services 12 VAC 5-371-220(D,E) Cross Reference to F-241	F 001	**12 VAC 5-371-110 Management and administration** **12 VAC 5-371-110 (B,2,3,) Cross Reference to F-225** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (D, E) Cross Reference to F-241** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (A) Cross Reference to F-246** **12 VAC 5-371 Maintenance and Housekeeping** **12 VAC 5-371 (A) Cross Reference to F-252**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 3/28/16

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F 001	Continued From Page 1 12 VAC 5-371-220 Nursing services 12 VAC 5-371-220(A) Cross Reference to F-246 12 VAC 5-371-370 Maintenance and Housekeeping 12 VAC 5-371-370 (A) Cross Reference to F-252 12 VAC 5-371-250 Resident Assessment and Care Plan 12 VAC 5-371-250 (A,D, E) Cross Reference to F-278 12 VAC 5-371-250 Resident Assessment and Care Plan 12 VAC 5-371-250(C, F, H, I) Cross Reference to F-280 12 VAC 5-371-200 Nursing Director 12 VAC 5-371-200 (B) Cross Reference to F-281 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(A,B) Cross Reference to F-309 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(A) Cross Reference to F-313 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(A,B) Cross Reference to F-323 12 VAC 5-371-370 Maintenance and Housekeeping 12VAC 5-371-370 (A) Cross Reference to F-323 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(D) Cross Reference to F-328 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(A) Cross Reference to F-329 12 VAC 5-371-110 Management and	F 001	**12 VAC 5-371-250 Resident Assessment and Care Plan** **12 VAC 5-371-250 (A,D,E) Cross Reference to F-278** **12 VAC 5-371-250 Resident Assessment and Care Plan** **12 VAC 5-371-250 (C,F,H,I) Cross Reference to F280** **12 VAC 5-371-200 Nursing Director** **12 VAC 5-371-200 (B) Cross Reference to F-281** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (A,B) Cross Reference to F-309** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (A) Cross Reference to F313** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (A,B) Cross Reference to F 323** **12 VAC 5-371 Maintenance and Housekeeping** **12 VAC 5-371 (A) Cross Reference to F-323**	

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F 001	Continued From Page 2 Administration 12 VAC 5-371-110 (J) Cross Reference to F-334 12VAC5-371-220. Nursing services. 12VAC5-371-220-(B) Cross Reference to F-369 12 VAC 5-371-300 Pharmaceutical Services 12 VAC 5-371-300(B) Cross Reference to F-425 12 VAC 5-371-180 Infection Control 12 VAC 5-371-180(A, B, C.1) Cross Reference to F-441 12VAC5-371-370. Maintenance and housekeeping 12VAC5-371-370.(A) Cross reference to 456 12 VAC 5-371-360 Clinical Records 12 VAC 5-371-360(A, E) Cross Reference to F-514 12 VAC 5-371-140 (a) Based on facility documentation review and staff interview, the facility staff failed for one employee, Employee #20 of 20 employees, to obtain a license check prior to hire. The findings included: On 3/3/16, a review of the employees files was conducted. Employee #20, a RN (registered nurse) did not have a license check on file prior to hire. On 3/3/16 at 11:00 AM, an interview was conducted with the business office specialist, Employee (F). She stated, "We did our own checks here, then we switched over and they are done on line by corporate." She went on to state, "Whatever you gave me (information not found in the employee file) is what it is."	F 001	**12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (D) Cross Reference to F-328** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (A) Cross Reference to F-329** **12 VAC 5-371-110 Maintenance and Administration** **12 VAC 5-371-110 (J) Cross Reference to F-334** **12 VAC 5-371-220 Nursing Services** **12 VAC 5-371-220 (B) Cross Reference to F-369** **12 VAC 5-371-300 Pharmaceutical Services** **12 VAC 5-371-300 (B) Cross Reference to F-425** **12 VAC 5-371-180 Infection Control** **12 VAC 5-371-180 (A,B,C,1) Cross Reference to F-441** **12 VAC 5-371-370 Maintenance and Housekeeping** **12 VAC 5-371-370 (A) Cross Reference to F-456** **12 VAC 5-371-360 Clinical Records** **12 VAC 5-371-360 (A,E) Cross Reference to F-514**	

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F 001	Continued From Page 3 On 3/3/16 at 4:15 PM, the Administrator and Nurse Consultant were notified of above findings. COV 32.1-12.6.01 Based on staff interview and facility documentation review, the facility failed to obtain a sworn statement prior to hire for two employees, Employee #11 and Employee #20 in a survey sample of 20 residents. The findings included: Review of the employee files was conducted on 3/3/16. Employee #11 was hired on 10/19/15. Her sworn statement was obtained after the hire date on 12/15/15. Employee #20 was hired on 8/5/15. There was no sworn statement included within the employee's file. On 3/3/16 at 11:00 AM, an interview was conducted with the business office specialist, Employee (F). She stated, "We did our own checks here, then we switched over and they are done on line by corporate." She went on to state, "Whatever you gave me (information not found in the employee file) is what it is." She also stated that Employee #20 was hired by a recruiter in Portsmouth and they did not send the file. On 3/3/16 at 4:15 PM, the Administrator and Nurse Consultant were notified of above findings. 1. 12 VAC 5-371-200 Nursing Director 12 VAC 5-371-200 (E) Based on the Code of Virginia and staff interview, the facility staff failed to notify the Office of Licensure and Certification (OLC) in writing with the name of the acting Director of Nursing (DON).	F 001	**12 VAC 5-371-140 (a)** **12 VAC 5-371-200 (E)** **COV 32.1-12.6.01** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** No Residents were found to be affected The facility resubmitted the written notification to the OLC of DON change dated 01/27/16 on 03/04/16 via fax. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents had the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Facility HR Generalist, Business Office Manager and Business Office Assistant verified and validated all License checks, sworn statements has been completed and are on file. The Executive Director in-serviced the Facility HR Generalist, Business Office Manager and Business Office Assistant on the requirements related to Licenses and Sworn Statements on new hires. An audit will be completed by the Business Office Assistant and or HR Generalist, or Business Office Manager to ensure compliance on all new hires weekly.	

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F 001	Continued From Page 4 The findings included: On 3/3/16 at 10:30 a.m., the acting DON told the survey team that she was flying back home and would not be available for the remainder of the survey. She stated that the Assistant DON would be available to answer questions. At this time, the DON was asked for the date when she officially began to function in the acting DON position. She stated the date was 1/27/16. On 3/3/16 at 1:00 p.m., the OLC was contacted to verify that they had received a written notification of the DON change. The OLC did not have any written notification of the DON change. At the end of day meeting on 3/3/16, the facility was asked to determine if the OLC had been notified of the DON change. The facility staff did not provide any further information.	F 001	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Executive Director and or Director of Nursing will review the audits monthly for 3 months and report the finding in QAPI for analysis and recommendation / follow up. **5.) Date Corrective Action will be completed.** **Compliance Date is April 4, 2016**	

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/1/16 through 3/4/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated. The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 26 current Resident reviews (Residents #1- #20, #25-28, and #30-31) and 5 closed record reviews (Residents #21-24 and #29).	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	**F 156** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #22 was discharged on 01/26/16. Resident #23 was discharged on 01/01/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents who receive an Advanced Beneficiary Notice (ABN) have the potential to be affected. An Audit was completed by the Business Office Manager and Social Worker and MDS Assessment Nurse by 04/01/16 to identify those residents who have received an Advanced Beneficiary Notice.	

RECEIVED
APR 01 2016
VDH/OLC

LABDRATDRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 3/28/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a	F 156	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The MDS Assessment Nurse, Social Worker, and Business Office Manager will be in-serviced by the Executive Director on Advanced Beneficiary Notification (ABN) process for completion and compliance. **4.) The Facility will monitor its performance to make sure solutions are sustained.** The MDS Assessment Nurse, Social Worker and Business Office Manager will meet monthly at the facility Triple Check process meeting to validate completion of the Advanced Beneficiary Notice (ABN) process. The results or findings will be presented and discussed in Quality Assurance and Performance Improvement (QAPI) meeting for 3 months for analysis and review **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016.	

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, the facility staff failed for two residents (Resident #23 and Resident #22) to provide written notification of the Advanced Beneficiary Notice (ABN). 1. Resident #23 did not have a written notification of the ABN as well as the demand bill information which was submitted late. 2. Resident #22 did not have a written notification of the ABN. The findings included: 1. Resident #23 was admitted to the facility on 10/23/15. Diagnoses included benign prostatic	F 156		

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F 156	Continued From page 3 hypertrophy, low potassium and dehydration. The most recent MDS (minimum data set) dated 10/30/15 coded the resident's BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. The MDS coded the resident as requiring extensive to total assistance of one to two staff members for ADL's (activities of daily living) such as bed mobility and transferring. Review of the resident's ABN dated 11/27/15 revealed the resident's responsible party (RP) was notified by phone of the ABN. No written documentation was provided. On 12/11/15, the facility received the following from the QIO: "This letter is a follow up... was that the doctor disagreed with your discharge/termination of services....The notice of non coverage was invalid...because it was not issued in a manner required by Medicare." On 3/3/16 at 10:40 AM, an interview was conducted with the business office manager (other E). She stated, "Kepro (name of QIO-quality improvement organization) did not receive the non coverage form in time." 2. Resident #22 did not have a written notification of the ABN. Resident #22 was admitted to the facility on 12/12/15. Diagnoses included pneumonia, Alzheimer's dementia and diabetes. The most recent MDS (minimum data set) dated 12/18/15 coded the resident's BIMS (brief interview of mental status) score of "5" out of a possible 15, or severe cognitive impairment. The MDS coded	F 156		

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F 156	Continued From page 4 the resident as requiring extensive to total assistance of one to two staff members for ADL's (activities of daily living) such as bed mobility and transferring. Review of the ABN dated 12/26/15 revealed the resident's responsible party (RP) was notified by phone of the ABN. No written documentation was provided. On 3/3/16 at 1:00 PM, the Administrator and nurse consultant were notified of above findings.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	**F 157** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The Physician and Responsible Party of Resident # 28 were notified of the blood sugar of 59 from 01/19/16 on 03/21/16 and there were no new orders. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents with blood sugar checks have the ability to be affected. An audit of blood sugar results for the last 30 days of current residents who have ordered blood sugar checks to identify results outside of designated parameters to verify results have been reported to the Physician and Responsible Party	

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F 157	Continued From page 5 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to inform the physician of a change in condition for one Resident (Resident #31) in a survey sample of 31 Residents. For Resident #28, the physician was not informed of a finger stick blood sugar of 59 mg/dl (milligrams per deciliter) on 1/19/16 at 6:30 a.m. per physician's order. The findings included: Resident #28, a female, was admitted to the facility 2/4/13. Her diagnoses included legally blind, anemia, atrial fibrillation, type II diabetes mellitus, chronic renal failure, chronic obstructive pulmonary disease, hyperlipidemia, peripheral vascular disease, congestive heart failure, transient ischemic attack, and hypertension. Resident #28's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/6/16 was coded as a quarterly assessment. Resident #28 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #28 was coded as needing minimal to stand by assistance of one staff	F 157	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Licensed Nursing Staff will be in-serviced by the Director of Nursing Services or Assistant Director of Nursing Services or Registered Nurse Supervisor by 04/01/16 on Physician Notification for Resident change in condition, including blood sugars that are out of parameters and other changes in condition. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Blood Sugars will be monitored in the Clinical Start Up meetings by the Director of Nursing Services, Assistant Director of Nursing Services or Unit Charge Nurses to ensure compliance with notification of change in condition. Results of monitors will be presented and discussed in Monthly Quality Assurance and Performance Improvement (QAPI) meetings for 3 months for analysis and review. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 6 member with her activities of daily living with the exception of bathing. For bathing, she was coded as requiring total assistance of one staff member. Review of Resident #28's clinical record revealed a signed physician's order that included, "5/25/15 Accucheck two times a day related to diabetes. Notify MD (Medical Doctor) of BS (blood sugar) less than 60 or greater than 400." The order was on the most recently "Order Summary Report" signed by the physician on 2/9/16. An "Accucheck" is a finger stick blood sugar. Review of the eMAR (electronic medication administration record) revealed an accompanying entry for the fingerstick blood sugar to be obtained twice a day. Documentation revealed the finger stick blood sugar obtained 1/1/19/16 at 6:30 a.m. was 59 mg/dl. A thorough review of the clinical record revealed no evidence Resident #28's physician was notified of the finger stick blood sugar level of 59 mg/dl. When interviewed, the ADON (assistant director of nursing) stated 3/4/16 at 11:10 a.m. that there was no evidence that Resident #28's physician had been informed of the finger stick blood sugar of 59 mg/dl. Review of the facility's 24 hour report also failed to reveal the physician had been informed. Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or	F 157		

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F 157	Continued From page 7 harm clients." The acting administrator, corporate consultant, and ADON were informed of the failure of the staff to inform Resident #28's physician of a finger stick blood sugar of 59 mg/dl, 3/4/16 at 12/10/16.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	**F 225** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** An investigation was completed for Resident #3 on 03/03/16 and the incident was reported to the Office of Licensure and Certification (OLC) on 03/03/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** The Executive Director or Director of Nursing Services or Assistant Director of Nursing or Charge Nurses will investigate injuries of unknown origins in a timely manner and report per State regulations to the appropriate agencies.	

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F 225	Continued From page 8 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed for 2 residents (Resident #3 and #8) of 31 residents in the survey sample to report and investigate injuries of unknown origin. 1. For Resident #3, an x-ray of the right foot completed on 2/26/16 revealed fractures of the third and fourth toes. The facility staff did not report the fractures to the Office of Licensure and Certification (OLC) and the facility staff did not investigate the fractures. 2. For Resident #8, the facility staff failed to notify the SA (state agency) of an injury of unknown origin that was observed on 6/26/15 until 6/30/15. "On 1/26/15 at 1900 (7 p.m.) resident was noted with a large red bruise on (R) (right) knee, no swelling or c/o (complaint of) tenderness noted to site." The findings included: Resident #3, a 90 year old, was admitted to the facility on 4/11/11. Her diagnoses included colon	F 225	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Staff will be in-serviced by the Director of Nursing or Assistant Director of Nursing or Executive Director on reporting injuries upon discovery per policy. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Clinical Progress notes, 24-hour nursing reports and diagnostic tests will be reviewed in Facility Clinical Start Up meetings for any possible injuries of unknown origins. The results of the reviews will be presented and discussed in our Quality Assurance and Performance Improvement monthly meetings for 3 months for analysis and review. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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cancer, diabetes, hypertension, degenerative joint disease and Methicillin-resistant Staphylococcus aureus (MRSA) in the right heel wound.

Resident #3's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 12/8/15. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with her activities of daily living.

Resident #3's physician order sheet was signed on 3/1/16. Included was the order "X-ray right foot (plain film)" dated 2/26/16.

A copy of the x-ray report was included in the clinical record. The report was time stamped 2/26/16 at 4:15 p.m. The section titled "Impressions" read "1. Nondisplaced fractures necks of the third and fourth metatarsals (toes), age indeterminate."

On 3/2/16, the x-ray report was reviewed with the unit manager, Licensed Practical Nurse G (LPN G). LPN G was asked if she was aware of the fracture. She stated yes. She stated that the doctor was also aware of the fracture. She referred to the x-ray report where staff initialed, hand wrote "____ (Orthopedic doctor) appt (appointment)" and dated 2/28/16.

When asked if the facility administration had been notified of the fractured toes, LPN G stated that the fractures were age indeterminate. When asked again if the administration was aware of the fractures, LPN G stated that the administration would have been notified during the morning meeting on 2/29/16.

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F 225	Continued From page 10 The facility administration was asked on 3/2/16 at the end of day meeting and again on 3/3/16 at the end of day meeting if they had reported and investigated Resident #3's broken toes. The facility administration did not provide any information regarding an investigation or notification to the OLC. The facility policy titled "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation" was reviewed. The policy read "It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violation") are reporting immediately to the Executive Director or Director of Nursing of the Living Center." The policy section titled "Reporting" read "If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately, but not later than 2 hours after forming the suspicion." "If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion." "The results of all investigations are reported to the ED (executive director) or designee and to the appropriate state agency, as required by stated law, within five working days of the alleged violation." 2. For Resident #8, the facility staff failed to notify the SA (state agency) of an injury of unknown origin that was observed on 6/26/15 until 6/30/15. "On 1/26/15 at 1900 (7 p.m.) resident was noted	F 225		

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with a large red bruise on (R) (right) knee, no swelling or c/o (complaint of) tenderness noted to site."

Resident #8, a female, was initially admitted to the facility 9/10/08 and readmitted after a hospitalization 8/4/10. Her diagnoses included hypothyroidism, dementia, major depressive disorder, unspecified psychosis, anxiety disorder, hypertension, arteriosclerotic cardiovascular disease, and gastroesophageal reflux disease.

Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/24/15 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required extensive to total assistance of one staff member to perform her activities of daily living.

Review of the facility reported incident (FRI) submitted to the SA on 6/30/15 revealed Resident #8 had been observed:

"On 1/26/15 at 1900 (7 p.m.) resident was noted with a large red bruise on (R) (right) knee, no swelling or c/o (complaint of) tenderness noted to site."

Documentation revealed Resident #8 was assessed by the staff, and the physician and her responsible party were informed on 6/26/15. The initial FRI to the state agency was dated 6/30/15 and no evidence was provided that the SA had been informed at the time of the discovery of the injury of unknown origin.

Review of the facility's policy entitled "Preventing,

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F 225	Continued From page 12 Investigating, and Reporting Alleged Sexual Assault and Abuse Violation" included: "Reporting: If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Failure to report in the required time frames may result in disciplinary action, including up to termination. Staff must report the suspicion of an incident to the Executive Director, Director of Nursing, or supervisor. The ED (executive director) notifies the appropriate state agency in accordance with state law and also notifies the regional vice president." The director of nursing was unable to be interviewed. The ED at the time of the incident was no longer with the facility at the time of survey. The corporate consultant was interviewed, 3/4/16 at 10:17 a.m. She stated she would investigate and attempt to determine why the injury of unknown origin had not been reported in a timely manner. As of the end of the survey, no rationale was provided as to why the injury had not been reported immediately to the SA. The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to report an injury of unknown origin to the SA in a timely manner, 3/4/16 at 12:15 p.m.	F 225		

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide personal privacy for two Residents (Residents' #1 and #5) in a survey sample of 31 Residents. 1. For Resident #1, LPN (licensed practical nurse) F did not pull the privacy curtain all the way around Resident #1's bed when doing wound care. Resident #1 could be seen from her roommate's side in the mirror; and 2. For Resident #5, LPN F did not pull the privacy curtain between Resident #5 and his roommate, allowing the roommate to see Resident #5 receiving wound care. The findings included: 1. For Resident #1, LPN (licensed practical nurse) F did not pull the privacy curtain all the way around Resident #1's bed when doing wound care. Resident #1 could be seen from her roommate's side in the mirror. Resident #1, a female, was admitted to the facility 6/13/13. Her diagnoses included sacral pressure ulcer, aphasia, contracture, Alzheimer's dementia, and hypertension.	F 241	**F 241** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #1 and #5 privacy curtains were immediately inspected and adjusted on 03/04/16 so they would provide privacy during care. Charge Nurse was immediately in-serviced on 03/04/16 on the need to provide full visual privacy while providing care to residents. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents have the potential to be affected. An inspection of identified privacy curtains was conducted by the Housekeeping on 03/04/16 and facility wide on 03/25/16 to ensure the curtains provided privacy for the residents.	

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F 241	Continued From page 14 Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/28/15 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total assistance of one to two staff members to perform her activities of daily living. Resident #1 was also coded as having one stage IV pressure ulcer. www.npuap.org defines a stage IV pressure ulcer: "Category/Stage IV: Full thickness tissue loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable." Resident #1 was observed receiving pressure ulcer wound care from LPN F, the facility's wound care nurse, 3/2/16 beginning at 8:45 a.m. After assembling his supplies, LPN F put down a barrier on the over bed table. LPN F closed the window curtain and pulled the privacy curtain between Resident #1 and her roommate. LPN F however, only pulled the privacy curtain to the end of Resident #1's bed. After removing the incontinent brief, LPN F	F 241	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Staff will be in-serviced by the Executive Director, Director of Nursing or Assistant Director of Nursing Services by 04/01/16 on need to ensure that privacy is provided whenever care is being provided. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Cubicle Curtain and Window Curtain audits will be conducted by the Director of Nursing Services or Assistant Director of Nursing Services or RN Supervisors 2 times per week for 1 month then monthly thereafter to ensure residents are provided privacy during care. Results of the audits will be presented and discussed in Quality Assurance and Process Improvement Meetings for 3 months for analysis and review. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 241	Continued From page 15 performed wound care per the physician's order. While standing and observing the procedure, Resident #1's roommate could be easily observed by looking into the mirror on the opposite side of the room at the end of Resident #1's bed. Upon exiting the room, Resident #1 could also be easily observed in the same mirror as noted above. At that time LPN F was reattaching Resident #1's incontinent brief. When interviewed, LPN F stated 3/3/16 at 3:40 p.m., he was unaware that Resident #1 could be seen in the mirror. LPN F said he should have pulled the curtain all of the way around Resident #1. Review of the facility policy entitled "Resident Rights" included: "The Resident has the right to personal privacy and confidentially of his or her personal and clinical records..." Guidance is provided by "Fundamentals of Nursing, 7 th Edition, Potter-Perry, p. 1314, Applying Dry And Moist Dressings, Steps 5. Close room or cubicle curtains and windows." Guidance is also provided in "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 331, The tort of invasion of privacy protects the client's right to be free from unwanted intrusion into his or her private affairs. HIPPAA (Health Insurance Portability and Accountability Act) Privacy Standards have raised awareness of the need for health care professionals to provide confidentiality and privacy...HIPPAA sets forth standards indicating that clients are entitled to confidential health care." The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of LPN F to pull the	F 241		

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F 241	Continued From page 16 privacy curtain all the way around Resident #1's bed during wound care, 3/4/16 at 12:15 p.m. 2. For Resident #5, LPN F did not pull the privacy curtain between Resident #5 and his roommate, allowing the roommate to see Resident #5 receiving wound care. Resident #5, a male, was admitted to the facility 2/26/16. His diagnoses included sepsis, hypolhyroidism, hyperlipidemia, seizure, Parkinson's, depression, hypertension, pulmonary embolism, gastrointestinal bleed, pneumonitis, influenza, and cerebrovascular accident. Resident #5 had not been at the facility long enough to have an MDS completed. Review of the admitting nursing assessment revealed he had been assessed as having memory deficits and required assistance with making life decisions. He was also assessed as requiring total assistance with his activities of daily living. He was documented as having a stage II pressure ulcer on his sacrum. www.npuap.com defines a stage II pressure ulcer: "Category/Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. *Bruising indicates deep tissue injury."	F 241		

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F 241	Continued From page 17 Resident #5 was observed receiving wound care from LPN F 3/3/16 beginning at 9:05 a.m. After assembling his supplies, LPN F put a barrier down on the over bed table. LPN F pulled the privacy curtain between Resident #5's bed and the door, to the end of Resident #5's bed. No privacy curtain was pulled between Resident #5 and his roommate. Resident #5's roommate was alert and sitting up in his bed. LPN F preceded to perform pressure ulcer wound care per physician's orders. When interviewed, 3/3/16 at 3:40 p.m., LPN F did not remember that the privacy curtain had not been pulled between Resident #5 and his roommate. LPN F stated he should have provided privacy while performing wound care for Resident #5. The acting administrator, ADON, and corporate consultant were informed of the failure of LPN F to provide privacy for Resident #5 during wound care, 3/4/16 at 12:15 p.m.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, facility documentation review, clinical record review the facility staff failed to	F 246	**F 246** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 27 Care Plan and Care Card was reviewed and updated to reflect the resident's and family's preference. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents have the potential to be affected. Nursing Services and Social Services will review the last 3 months of concerns and grievances and care plan meeting notes for specific preferences and ensure that these have been care planned and communicated to the appropriate departments.	

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F 246	Continued From page 18 accommodate the needs of one resident (Resident # 27) in a survey sample of 31 residents. For Resident # 27, the facility staff failed to get her out of bed timely per her and her family's preference. Findings included: Resident # 27 was a 60 year old female admitted to the facility on 2/18/2012 with the diagnoses of, but not limited to, Type 1 Diabetes Mellitus, Stroke, Hemiplegia and Hemiparesis, Aphasia, Gastrostomy, Major Depressive Disorder, Single Episode, Hypertension, Gastroesophageal Reflux Disease (GERD), and Cataract. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/19/2016. The MDS coded Resident # 27 with cognitive status as moderately impaired; required extensive assistance of one to two staff members with activities of daily living and always incontinent of bowel and bladder. On 3/3/2016 at 10:15 AM, observed Resident # 27 lying in bed, lying on right side facing door, tube feeding infusing. 3/3/2016 at 11:30 AM, observed Resident # 27 still lying in bed. On 3/3/2016 at 11:35 AM, observed privacy curtain pulled around bed. Husband was washing Resident 27 ' s face. Husband stated " her face was dirty with drool " when he arrived. Husband stated he was very upset because every day his wife was still in the bed at 11:30 when he would	F 246	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Staff will be in-serviced by the Director of Nursing or Assistant Director of Nursing or Social Worker or Social Worker Assistant on the need to follow resident or family preferences for care by 04/01/16 by following preferences on Care Cards and Plans of Care. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Resident and family preferences will be reviewed through the care plan meeting and grievance process. Care Plan meeting notes and Grievance Tracking logs will be audited monthly for 3 months by the Assistant Director of Nursing Services and Social Worker or Social Worker Assistant to ensure compliance. The results of these audits and reviews will be presented and discussed in the Quality Assurance and Process Improvement Meetings for 3 months for analysis and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 246	Continued From page 19 visit. Stated the staff would get her up after he arrived and then put her back to bed by 2 PM each day. Husband stated he would " just bathe her " because it did " not make sense for her to have to stay in the bed all day. " Husband stated she needed to be up and able to be around other people. On 3/3/2016 interview conducted with Resident # 27 ' s husband who stated he had several meetings with the Executive Director and Director of Nursing about caring for Resident # 27. Husband stated he requested that she receive morning care and get out of bed before 11:30 AM and for staff to take her to attend activities with other residents. Husband stated that his "wife loved being around other people and could benefit from the stimulation of being with others in Activities" even though she could not talk. Husband stated he spoke with the Activities Coordinator about making sure his wife was in the Activity Room when activities were going on such as music, Bingo and trivia. Husband stated he usually came to the facility to visit his wife "at around 11:30 AM and would stay for 3-4 hours each day." Husband stated he met with staff to determine "what we could do but things got progressively worse, staff quit and she was left in the bed longer and longer each day." Husband stated he felt that caring for his wife was a joint effort and he was willing to work with the staff but felt very upset that she remained in bed until after 11:30 AM on most days. Husband stated his wife was young and needed to be kept active. On 3/3/2016 at 3 PM, an interview was conducted with RN (Registered Nurse) B who stated she would make sure the staff got Resident # 27 out of bed early each day and taken to activities. RN B stated Resident # 27 could be gotten out of bed	F 246		

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F 246	Continued From page 20 early since that was their preference and would benefit from attending activities. On 3/3/2016 at 3:05 PM, an interview was conducted with the Activities Coordinator (Other A) who stated Resident # 27 was very seldom up during the times of the activities programming. Other A stated Resident # 27 was usually up at 11 or 11:30 and back to bed by 2 PM. Other A stated Activities Department conducted a Restorative Nursing Dining Program at 11:30 AM that lasted until at least 1:30 PM each day. Other A stated she had talked with the nursing department several times and now there was new staff. Other A stated sometimes the staff told her Resident # 27 did not want to get up and would get agitated. 3/3/2016 at 4:30 PM, interview was conducted with Activities Assistant (Other M) who stated she would love to have Resident # 27 attend activities but Resident # 27 was usually out of bed only during the times the Restorative Nursing Eating program was going on. Other M stated there were times when Resident # 27 seemed to be agitated when Other M did try to take her to activities that were going on while the resident was out of bed. Other M stated that if the nursing staff got Resident # 27 out of bed, she could attend many of the group activities like music and any other activities that did not involve food since she was fed by a tube. 3/4/2016 at 10:00 AM, observed Resident # 27 sitting in her wheelchair with tube feeding pole attached sitting in the Activities Room during a group activity. There were approximately 15 other residents in the Activity Room. Resident # 27 was dressed appropriately, well groomed and	F 246		

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F 246	Continued From page 21 was alert and looking around. Other M stated Resident # 27 seemed to be doing well in the activity. 3/4/2016 at 10:15 AM, an interview was conducted with the Social Services Director (Other D) who stated Resident # 27's husband has complained about getting his wife out of bed earlier than 11:30 AM. Surveyor requested to review any concern reports written in the past 6 months regarding Resident # 27. 3/4/2016 at 11:35 AM, observed Resident # 27 being wheeled by the Activity staff in the hallway near her room, husband and two other visitors were standing nearby. Resident #27's husband stated he was very happy to see her up and attending an activity. Resident # 27 smiled when her husband spoke to her. 3/4/2016 at approximately 12 noon, Other D presented two "Concern Reports" dated 10/19/2015 and 11/26/2015. The report dated 10/19/2015 stated Resident # 27's husband was very upset because " wife in bed playing in her stool, someone told him " they were short staffed. Both reports were reviewed and signed by the Social Services Director and Administrator within 24 hours of each report. The staff interviewed stated Resident # 27 was often in bed at 11:30 AM. Documentation showed the facility staff was aware of the concerns expressed by the husband.	F 246		
F 252 SS=D	COMPLAINT DEFICIENCY 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE	F 252	**F 252** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** No Residents were found to be affected. Housekeeping cleaned the area.	

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F 252	Continued From page 22 ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean environment for one of two shower rooms. The shower room floor on Unit two had several dark brown spots on the floor. LPN (A)(licensed practical nurse) was shown the shower room floor. She gloved, obtained a paper towel and scrubbed at the floor. She stated, "It flakes right up." On 3/3/16 at 9:00 AM, the shower room was observed to be clean and the floor was free from the dark brown spots. On 3/3/16 at 4:15 PM, the Administrator and nurse consultant were notified of above findings.	F 252	**2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All Residents of Unit Two had the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Housekeeping Department will be in-serviced by the Executive Director or designee by 04/01/16 on the need to provide a clean environment for the shower rooms. Environmental Round Audits will be conducted daily Monday through Friday by the Housekeeping Manager or Housekeeping Assistant to check these areas. The Housekeeping Department will ensure the Shower Rooms are cleaned daily.	
F 278 SS=E	COMPLAINT DEFICIENCY 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Executive Director or Management Designee will audit the Shower Rooms weekly on an on-going basis. The results of audit results will be presented and discussed in QAPI monthly meeting for analysis and review and recommendations and follow up as necessary for 3 months. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 278	Continued From page 23 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure an accurate and timely Minimum Data Set/Resident Assessment Instrument (MDS/RAI) assessment was completed for four residents (Residents # 11, #12, #7 and # 4) in a survey sample of 31 residents. 1. For Resident # 11, the facility staff failed to complete Section C: Cognitive Patterns in an annual assessment dated 12/10/2015. 2. For Resident # 12, the facility staff failed to	F 278	**F 278** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #11, 12 and 4 Interdisciplinary Team (IDT) will be in-serviced on completion of Section C on the Minimum Data Set /Resident Assessment Instrument MDS/RAI Resident #7 Modification was completed on 03/24/16 with ARD of 02/02/16 to accurately reflect the use of an anti depressant. Interdisciplinary team will be in-serviced on timeliness of MDS. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Assistant Director of Nursing / Designee will complete a review of MDS assessments completed within the last 30 days to determine accurate coding of the presence of anti depressants. Residents with inaccurate coding will be modified as needed. Assistant Director of Nursing/Designee will complete a review of MDS assessments completed within the last 30 days to determine Section C was completed.	

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F 278	Continued From page 24 complete Section C: Cognitive Patterns in the quarterly assessment with an ARD of 2/1/2016. 3. Resident #7's MDS was signed late and her use of an antidepressant was not coded. 4. Resident #4's cognitive section (C) was not filled out and contained only dashes. Findings included: 1. For Resident # 11, the facility staff failed to complete Section C: Cognitive Patterns in an annual assessment dated 12/10/2015. Resident # 11, a 68 year old female, was admitted to the facility 8/27/11. Her diagnoses included but not limited to End Stage Renal Disease, Ileostomy, Hyperkalemia, Dementia, Major Depressive Disorder, Cardiomyopathies, Hemodialysis and Hypertension. Resident # 11's most recent MDS (minimum data set) with an ARD (Assessment Reference Date) of 12/10/2015 was coded as an annual assessment. Resident # 11's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 11 was coded as needing limited to extensive assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident # 11 was coded as needing only limited assistance. Resident #11 was coded as being able to hear, speak, understand, and be understood.	F 278	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Director of Resident Assessment or Designee will provide education to the Interdisciplinary team on the coding for Section C, timeliness of MDS and coding of use of antidepressants **4.) The Facility will monitor its performance to make sure solutions are sustained.** The Assistant Director of Nursing will audit a minimum of 3 MDS weekly to determine the accuracy of coding antidepressants and Section C. Findings will be discussed in the Quality Assurance Process Improvement monthly meeting for 3 months by Director of Nursing or Designee. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 278	Continued From page 25 Guidance was provided in "Long Term Care Facility Resident Assessment User's Manual Version 3.0 May 2013, p. C-3 "Steps for Assessment 1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status. 2. Review Language item (A1100), to determine if the resident needs or wants an interpreter. · If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions Record whether the cognitive interview should be attempted with the resident. Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. · Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words. CMS ' s RAI Version 3.0 Manual CH 3: MDS Items [C] May 2013 Page C-2 C0100: Should Brief Interview for Mental Status Be Conducted? (cont.) Coding Tips · If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a	F 278		

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F 278	Continued From page 26 needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status. · Includes residents who use American Sign Language (ASL). C0200-C0500: Brief Interview for Mental Status (BIMS)" Also, same reference p. 3-4: "Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed. - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes. - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled. - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD-9 diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS	F 278		

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F 278	Continued From page 27 MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html" The administrator, DON (director of nursing), and corporate consultants were informed of the failure of the staff to complete Section C100-C1000 accurately for an annual MDS with the ARD of 12/10/2015 during the end of day debriefing on 3/2/2016. On 3/3/2016 at 5:20 PM, an interview was conducted with Registered Nurse Assessment Coordinator (RN C) who stated that dashes on the MDS (Minimum Data Set) meant the staff did not complete the interview, but the interviews still needed to be completed. RN C stated the previous Registered Nurse Assessment Coordinator was out sick for 3 weeks prior to resigning in February. RNC again stated the MDS should be complete and timely. No further information was provided. 2. For Resident # 12, the facility staff failed to complete Section C: Cognitive Patterns in the quarterly assessment with an ARD of 2/1/2016. Resident # 12, a 69 year old female, was admitted to the facility 12/8/2014. Her diagnoses included but not limited to Psychosis, Diabetes, Morbid Obesity, Major Depressive Disorder, Anxiety, Hypertension and history of Intestinal Obstruction. Resident # 12's most recent MDS with an ARD of 2/1/2016 was coded as a quarterly assessment.	F 278		

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F 278	Continued From page 28 Resident # 12's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 12 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident # 12 was coded as needing only limited assistance. Resident #12 was coded as always incontinent of bowel and bladder. Resident #12 was coded as being able to hear, speak, understand, and be understood. The administrator, DON (director of nursing), and corporate consultants were informed of the failure of the staff to complete Section C100-C1000 accurately for an annual MDS with the ARD of 12/10/2015 during the end of day debriefing on 3/2/2016. On 3/3/2016 at 5:20 PM, an interview was conducted with Registered Nurse Assessment Coordinator (RN C) who stated that dashes on the MDS (Minimum Data Set) meant the staff did not complete the interview, but the interviews still needed to be completed. RN C stated the previous Registered Nurse Assessment Coordinator was out sick for 3 weeks prior to resigning in February. RNC again stated the MDS should be complete and timely. No further information was provided. 3. Resident #7's MDS assessment was signed late and her use of an antidepressant was not coded. Resident #7 was admitted to the facility on 6/30/14. Diagnoses included COPD (chronic	F 278		

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F 278	Continued From page 29 obstructive pulmonary disease), anemia, and schizophrenia. The most recent MDS (minimum data set) dated 2/2/16 coded the resident's BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. The MDS coded the resident as requiring supervision assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. The resident was coded as having been treated with an antipsychotic and antianxiety daily for the past seven days of the ARD period. Review of the MAR (medication administration record) showed that Resident #7 had been treated with an antidepressant (Doxepin) daily for the past seven days of the ARD period. This was not coded on the MDS. In addition, the Z500 Date (date RN-registered nurse) signed as complete) was more than 14 days after the ARD. The Z500 date was 2/23/16. On 3/3/2016 at 5:20 PM, an interview was conducted with Registered Nurse Assessment Coordinator (RN C) who stated that dashes on the MDS (Minimum Data Set) meant the staff did not complete the interview, but the interviews still needed to be completed. RN C stated the previous Registered Nurse Assessment Coordinator was out sick for 3 weeks prior to resigning in February. RNC again stated the MDS should be complete and timely. **4.** Resident #4's cognitive section (C) was not filled out and contained only dashes and was signed late. Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The	F 278		

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GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

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F 278	Continued From page 30 most recent MDS (minimum data set) dated 2/3/16 did not code the resident's BIMS (brief interview of mental status) score nor had his cognitive status been assessed, but contained only dashes. The previous MDS had coded the BIMS score as "7" out of a possible 15 or moderate cognitive impairment. The MDS coded the resident as requiring total assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. Review of the MDS dated 2/3/16 had no information documented as to the resident's cognitive status, only dashes were coded for the cognitive section. In addition, the resident's Z500 Date (date RN-registered nurse) signed as complete) was more than 14 days after the ARD. The Z500 date was 2/23/16. The DON (director of nursing) stated, "Dashes are there because the assessment was completed late; corporate told us to do that. Review of the RAI (resident assessment instrument) manual, page 219, read as followed: "Item Z500 must be no later than 14 days after the ARD. On 3/2/16 at 5:00 PM, the Administrator and DON were notified of above findings.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	**F 280** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 8 Care Plan and Care Card were updated to reflect the order for having food placed in individual bowls and dietary department notified.	

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F 280	Continued From page 31 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to review or revise the comprehensive plan of care for one Resident (Resident #8) in a survey sample of 31 Residents. For Resident #8, the use of physician ordered separate bowls for food was not care planned. The findings included: Resident #8, a female, was initially admitted to the facility 9/10/08 and readmitted after a hospitalization 8/4/10. Her diagnoses included hypothyroidism, dementia, major depressive disorder, unspecified psychosis, anxiety disorder, hypertension, arteriosclerotic cardiovascular disease, and gastroesophageal reflux disease. Resident #8's most recent MDS (minimum data	F 280	**2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents who use adaptive equipment have the potential to be affected and an audit was conducted by the Dietary Services Manager by 03/21/16 of residents with orders for adaptive equipment to ensure that they were reflected on the Care Plan, Care Card and Dietary Matrix. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Dietary Staff were in-serviced by the Dietary Services Manager by 03/25/16 that Physicians Orders for adaptive equipment must be followed. New orders will be reviewed in clinical start up and updated as needed on Care Plans and Care Cards. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits will be conducted by the Dietary Services Manager or Unit Managers weekly for 1 month then monthly for 3 months to ensure compliance and the results of these audits will be brought through the monthly QAPI meeting for discussion and further analysis and recommendations and follow up / action steps. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 280	Continued From page 32	F 280		

set) with an ARD (assessment reference date) of 11/24/15 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required extensive to total assistance of one staff member to perform her activities of daily living.

Resident #8 was observed in the restorative dining room, 3/2/16 at 12:10 p.m. She was sitting at a table and the staff brought her plate with her lunch. The plate contained meat and potatoes with gravy. In a small separate bowl was broccoli. She had thickened liquids to drink.

Review of Resident #8's clinical record revealed the following physician's order, "8/19/14 Pt (patient) to have food placed in individual bowls at all meals in order to increase independence with self feeding." The order was on the most recently signed "Order Summary Report" dated as signed 2/17/16.

Review of Resident #8's comprehensive care plan revealed a care plan had been developed 3/18/15 for "Inadequate Oral Food/Beverage intake due to Dementia. Food and beverage intake less than required. Resident is now receiving appetite stimulant and PO (by mouth) intake has improved.

Included in the "Interventions" were:

*Administer supplemental medications as ordered
*Clothing protector as desired
*Diet as ordered
*Identify the food and placement on plate/table during meals
*Invite to food related activities
*Medication review by pharmacist

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F 280	Continued From page 33 *Monitor for S/Sx (signs and symptoms) of depression *Monitor meal consumption daily *Monitoring through Weight Management Committee *Monthly weights *Notify Physician and family/responsible party of weight change *Obtain and update food/beverage preferences *Provide assistance with meals *Screen/evaluation by rehab services prn (as needed) *Supplements and/or snacks as ordered" A thorough review of Resident #8's clinical record revealed no evidence the use of separate bowls had been care planned. When interviewed, the DON (director of nursing) stated 3/2/16 at 3:30 p.m., the staff utilized the care plan to know how to meet Resident's needs. She further stated the CNA (certified nursing assistants) had a "Resident Kardex" that provided guidance to them for Resident needs. The "Resident Kardex" for Resident #8 was reviewed. While her diet was listed and that she ate in the "activity room for lunch and dinner" no information was provided that Resident #8 was to have individual bowls for all of her food. Guidance for the creation of an individualized care plan is provided by "Fundamentals of Nursing 7th Edition, Potter-Perry, page. 268: In any health care setting a nurse is responsible for providing a written pan of care for all clients. The plan of care sometimes takes several forms...In hospitals and community-based	F 280		

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F 280	Continued From page 34 settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another." The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to ensure the use of individual bowls for all foods to foster independence in eating to be care planned, 3/4/16 at 12:15 p.m.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	**F 281** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Residents #1, 8, 17, 20, 28, and 2 were assessed for any adverse side effects from missed treatments and medications and none were found. These residents' physicians were notified of the missed treatments by 03/21/16 and there were no new orders.	

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F 281	Continued From page 35 by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for seven Residents (Residents' #1, #8, #17, #20, #28, #4 and #2) in a survey sample of 31 Residents. 1. For Resident #1, the facility staff failed to administer treatments as ordered by the physician; 2. For Resident #8, the facility staff failed to ensure treatments were administered as ordered by the physician; 3. For Resident #17, the facility staff failed to administer medications and treatments as ordered by the physician, 4. For Resident #20, the facility staff failed to administer medications and treatments as ordered by the physician; 5. For Resident #28, the facility staff failed to administer treatments as ordered by the physician; 6. For Resident #4, the facility failed to document medications, including an antibiotic; and 7. For Resident #2, the facility staff failed to document treatments as having been performed per physician's orders. The findings included: 1. For Resident #1, the facility staff failed to administer treatments as ordered by the	F 281	**2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** The Field Services Clinical Director will in-service the Director of Nursing on monitoring administration and documentation of treatments and medications to ensure Physician orders are followed. Licensed nurses will be in-serviced by the Director of Nursing or Assistant Director of Nursing on Medication Management Guidelines regarding administration and documentation of treatments and medications by 04/01/16. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Medication and Treatment Administration Records will be reviewed at the Clinical Start up Meeting for completion and appropriate follow up. **4.) The Facility will monitor its performance to make sure solutions are sustained.** The Results of The review of the Medication and Treatment Administration Records completed in Clinical Start up will be presented and discussed in Quality Assurance and Process Improvement meetings monthly for 3 months for analysis and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 281	Continued From page 36 physician, Resident #1, a female, was admitted to the facility 6/13/13. Her diagnoses included sacral pressure ulcer, aphasia, contracture, Alzheimer's dementia, and hypertension. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/28/15 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total assistance of one to two staff members to perform her activities of daily living. Resident #1 was also coded as having one stage IV pressure ulcer. Review of Resident #1's clinical record revealed the following treatments were not administered: MA 65 every shift for pressure ulcer (specialty low air loss mattress): 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 Day shift, 2/8/16 day shift Apply Sure prep pad to left lateral foot every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift Bilateral 1/2 side rails to assist with bed mobility every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift Catheter care every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift	F 281		

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F 281	Continued From page 37 silver absorbing dressing twice daily and cover with foam dressing: 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift 18 Indwelling Foley catheter with 10 cc (cubic centimeter) bulb secured with anchor every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift. 2/8/16 day shift Abdominal binder at all times every shift: 1/5/16 evening shift, /23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift Apply foam dressing to sheer wound of the coccyx: 1/23/16, 1/24/16, 1/29/16, 2/24/16 Selsun Blue shampoo three times weekly: 1/29/16 Valid physician's orders were evident for the treatments in question. Review of the clinical record revealed no evidence Resident #1 refused the treatments in question, nor that she was out of the facility. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "Documentation: 1). The individual who administers the medication dose records the administration on the resident's MAR (medication administration record) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered	F 281		

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F 281	Continued From page 38 and documented. In no case should the individual who administer the medications report off-duty without first recording the administration of any medications. " When interviewed, RN (registered nurse) B stated 3/2/16 at 3:15 p.m., the administration of treatments followed the same standards as medications and should be documented as having been administered. After reviewing the documentation for the treatments, RN B stated the treatment nurse traditionally did all the treatments in the facility and was responsible for documenting them. RN B said on the days in question, the treatment nurse had to pass medications and that each nurse would have been responsible for their treatments. RN B stated she did not know if the treatments had been done, however she did not think they had been administered on the days in question. Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time	F 281		

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F 281	Continued From page 39 6. The right documentation." The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to administer the treatments indicated to Resident #1 per physician's orders, 3/4/16 at 12:15 p.m. 2. For Resident #8, the facility staff failed to ensure treatments were administered as ordered by the physician. Resident #8, a female, was initially admitted to the facility 9/10/08 and readmitted after a hospitalization 8/4/10. Her diagnoses included hypothyroidism, dementia, major depressive disorder, unspecified psychosis, anxiety disorder, hypertension, arteriosclerotic cardiovascular disease, and gastroesophageal reflux disease. Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/24/15 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required extensive to total assistance of one staff member to perform her activities of daily living. Review of Resident #8's clinical record revealed no evidence the following treatments were administered on the days listed: Chair alarm every day and evening shift: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift assist side rails on bed to assist with positioning and mobility every shift: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift	F 281		

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F 281	Continued From page 40 Bed alarm: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Geri sleeves every shift to bilateral arms: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Pads to arms of wheelchair at all times: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Remove lap buddy from wheelchair for 10 min every 1 hr (hour) and @ meal times: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Wander guard continuous every shift: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Valid physician's orders were evident for the treatments not documented as having been administered. Review of the clinical record revealed no evidence Resident #8 had refused the treatments or was out of the building during the time the treatments would have been administered. When interviewed, RN (registered nurse) B stated 3/2/16 at 3:15 p.m., the administration of treatments followed the same standards as medications and should be documented as having been administered. After reviewing the documentation for the treatments, RN B stated the treatment nurse traditionally did all the treatments in the facility and was responsible for documenting them. RN B said on the days in question, the treatment nurse had to pass medications and that each nurse would have been responsible for the treatments. RN B stated she did not know if the treatments had been done, however she did not think they had been administered on the days in question.	F 281		

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F 281	Continued From page 41 The acting administrator, ADON, and corporate consultant were informed of the failure of the staff to administer the treatments indicated to Resident #8 per physician's orders, 3/4/16 at 12:15 p.m. 3. For Resident #17, the facility staff failed to administer medications and treatments as ordered by the physician. Resident #17, a female, was initially admitted to the facility 4/1/10 and readmitted after a hospitalization 4/29/14. Her diagnoses included seizures, type II diabetes mellitus, cataract, depression, constipation, hyperlipidemia, peripheral vascular disease, gastroesophageal reflux disease, and hypertension. Resident #17's most recent MDS with an ARD of 2/18/16 was coded as a quarterly assessment. Resident #17 was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing limited to extensive assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing she was coded as requiring total assistance of one staff member. Review of Resident #17's clinical record revealed no evidence the following medication and treatments were administered: Monitor blood pressure and pulse q (every) week: No pulses were obtained for the following weeks 1/7/16, 1/14/16, 1/21/16, 1/28/16, 2/4/16, 2/11/16, 2/18/16. and 2/25/16 Tylenol 8 hour extended release 650 1 tablet every 8 hours: 2/21/16 at 2 p.m., 2/26/16 at 2	F 281		

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	495252	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

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F 281	Continued From page 42 p.m. Gold Bond cream every shift to abdominal folds: 2/14/15 on evening and night shift Sure prep to first metatarsal on right foot every shift: 2/1/4/16 on evening and night shift When interviewed, RN B stated 3/3/16 at 2:18 p.m., the nurse that entered the order for blood pressure and pulse to be obtained weekly in the computer, did not put the order in correctly. No area was entered for the pulse to be documented, therefore the nurse did not obtain the pulse. RN B was unable to determine if the medications and treatments had been administered or were not administered. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "Administration 2). Medications are administered in accordance with written orders of the prescriber. Documentation: 3). The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are cross referenced to a full signature in the space provided or on an applicable signature log." The acting administrator, ADON (assistant director of nursing, and corporate consultant were informed of the failure of the staff to administer	F 281		

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F 281	Continued From page 43 medications and treatments as indicated to Resident #17 per physician's orders, 3/4/16 at 12:15 p.m. 4. For Resident #20, the facility staff failed to administer medications and treatments as ordered by the physician. Resident #20, a female, was admitted to the facility 11/1/13. Her diagnoses included Parkinson's, anxiety, chronic obstructive pulmonary disease, anemia, hyperlipidemia, cerebral pseudo sclerosis, epidemic vertigo, dementia, unspecified psychosis, paranoid delusions, osteoarthritis, and congestive heart failure. Resident #20's most recent MDS with an ARD of 12/1/15 was coded as a quarterly assessment. Resident #20 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #20 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident #20 was coded as requiring standby assistance of one staff member. Review of Resident #20's clinical record revealed no evidence the following medications and treatments were administered: Greers goo apply to buttocks q (every) shift and as needed: 1/15/16 on evening shift, 1/31/16 night shift, 2/14/16 on evening and night shift MA 65 air mattress every shift: 1/15/16 on evening shift, 1/31/16 night shift, 2/14/16 on evening and night shift	F 281		

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F 281	Continued From page 44 Monitor sutures to right thigh: 1/15/16 on evening shift, 1/31/6 night shift, 2/14/16 on evening and night shift FerrouSul tablet 325 mg (milligram) by mouth three times a day: 2/21/16 1 p.m., 2/26/16 1 p.m. A valid physician's order was evident for all the medications and treatments in question. Review of the clinical record revealed no evidence Resident was out of the facility or had refused the medication or treatments in question. Prior to the end of the survey, no evidence was presented to determine if the medications and treatments were not administered or if they were administered and not documented. The acting administrator, ADON, and corporate consultant were informed of the failure of the staff to administer medications and treatments as indicated to Resident #20 per physician's orders, 3/4/16 at 12:15 p.m. 5. For Resident #28, the facility staff failed to administer treatments as ordered by the physician. Resident #28, a female, was admitted to the facility 2/4/13. Her diagnoses included legally blind, anemia, atrial fibrillation, type II diabetes mellitus, chronic renal failure, chronic obstructive pulmonary disease, hyperlipidemia, peripheral vascular disease, congestive heart failure, transient ischemic attack, and hypertension. Resident #28's most recent MDS (minimum data set) with an ARD (assessment reference date) of	F 281		

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F 281	Continued From page 45 1/6/16 was coded as a quarterly assessment. Resident #28 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #28 was coded as needing minimal to stand by assistance of one staff member with her activities of daily living with the exception of bathing. For bathing, she was coded as requiring total assistance of one staff member. Review of Resident #28's clinical record revealed no evidence the following treatments were administered per physician's orders: Barrier cream every day: 1/23/16, 1/24/16, 1/29/16 A thorough review of the clinical record revealed no indication that Resident #28 refused the treatment or was not at the facility on the days in question. A valid physician's order was evident for the treatment. The acting administrator, ADON, and corporate consultant were informed of the failure of the staff to administer barrier cream daily on 1/23. 1/24. and 1/29/16, 3/4/16 at 12:15 p.m. 6. For Resident #4, the facility failed to document medications, including an antibiotic. Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The most recent MDS (minimum data set) dated 2/3/16 did not code the resident's BIMS (brief interview of mental status) score nor had his cognitive status been assessed, but contained only dashes. The previous MDS had coded the	F 281		

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F 281	Continued From page 46 BIMS score as "7" out of a possible 15 or moderate cognitive impairment. The MDS coded the resident as requiring total assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. Review of the MAR (medication administration record) for February 2016 revealed several medications not documented as given. These are the omissions: 2/6/16: 2:00 PM- Humalog 3 units subcutaneously every 8 hrs 2/21/16: 12:00 PM- Clindamycin (antibiotic)150 mg (milligrams) every 6 hours for pneumonia 2/21/16: 12:00 PM- Duoneb (nebulized bronchodilator) one every 6 hours for pneumonia 2/6/16: 1:00 PM- Ferrous sulfate 325 mg (iron supplement) one tablet three times daily 2/21/16: 1:00 PM- Ferrous sulfate- 7.5 cc (cubic centimeters) three times daily 2/21/16: 2:00 PM- Seroquel (antipsychotic) 25 mg every 8 hours 2/6/16: 1:00 PM- Seroquel 50 mg three times daily On 3/2/16 at 5:00 PM, the Administrator and DON (director of nursing) were notified of above findings. The DON stated, "The medications should be signed when given." 7. For Resident #2, the facility staff failed to perform treatments as ordered by the physician. Resident # 2 was admitted to the facility on 10/7/13 and readmitted after a hospitalization on 1/14/16. Her diagnoses included, but not limited to, diabetes, anemia, hypertension, heart disease, peripheral vascular disease, and aphasia (a communication disorder)	F 281		

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F 281	Continued From page 47 The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/21/16. The MDS coded Resident # 2 with cognitive status as severely impaired; required total assistance with activities of daily living (ADLs) and always incontinent of bowel and as having an indwelling catheter for bladder elimination. Resident #2 was coded as receiving nutrition by way of a feeding tube and for having a Stage IV pressure ulcer. The MDS describes as Stage IV pressure ulcer as follows, "Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed.) Review of Resident #2's clinical record revealed no evidence that the following treatments were administered: "Medihoney Wound/Burn Dressing Gel. Apply to Right Middle Shin topically every day shift for open area. Clean with NS (normal Saline) and apply Medihoney and cover with dry dressing - 1/23, 1/24, 1/29/16. Santyl Ointment 250 unit/gm (gram), Apply to sacrum topically every day shift for sacral wound. Clean with NS and cover with alldress - 1/23, 1/29/16. Barrier Cream to bilateral buttocks q (every) shift for excoriation- 1/5/16, evening shift. Heel lift boot to left foot every shift for prevention - 1/5/16 evening shift. Monitor wound vac every shift for pressure ulcer -	F 281		

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F 281	Continued From page 48 1/5/16 evening shift. Silver Absorbent Dressing to right middle shin - 1/5/16 evening shift. Wound Vac continuous every shift for pressure ulcer - 1/5/16, evening shift." A valid physician's order was evident for the treatments in question. On 3/2/16 at 5:00 p.m., the director of nursing was informed of the treatments that were not documented as having been administered. The facility cited Lippincott as their reference for professional standards. On 3/4/16, at 2:15 p.m., the administrator and corporate consultants were informed of the failure of the staff to ensure treatments were documented as performed per physician's orders for Resident #2.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical	F 309	**F 309** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 29 expired on 01/04/16. Residents 1, 2, 4, 6, 8, 17, 20, 28 were assessed for any adverse side effects from missed treatments or medications and found to have none. These residents are currently receiving medications and treatments as ordered. The residents' physicians were notified by 03/21/16 of the missed treatments and medications with no new orders received. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** The Field Services Clinical Director will educate the Director of Nursing Services on Validation, medications obtained and administered. Licenses nursing staff will be in-serviced by 04/01/16 by the Director of Nursing Services, or Assistant Director of Nursing Services on Medication Administration Guidelines, ordering medications from the pharmacy, medications available in the Automatic Dispensing Unit (ADU) and utilizing the Emergency Drug Kits (EDK) to obtain medications as needed. The Director of Nursing or Assistant Director of Nursing will educate nurses on documenting medications and treatments as administered.	

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F 309	Continued From page 49 record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care and services to attain or maintain the highest practicable well being for nine Residents (Residents' #29, #6, #1, #8, #17, #20, #28, #4 and #2) in a survey sample of 31 Residents. 1. For Resident #29, the facility staff failed to administer Enoxaparin (a blood thinner) and Ciprofloxacin (an antibiotic) per physician's orders; and 2. For Resident #1, the facility staff failed to administer treatments as ordered by the physician; 3. For Resident #6, the facility staff failed to ensure treatments were administered as ordered by the physician; 4. For Resident #17, the facility staff failed to administer medications and treatments as ordered by the physician; 5. For Resident #20, the facility staff failed to administer medications and treatments as ordered by the physician; 6. For Resident #28, the facility staff failed to administer treatments as ordered by the physician; 7. For Resident #4, the facility failed to administer medications, including an antibiotic; 8. For Resident #2, the facility staff failed to perform treatments as per physician's orders.	F 309	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Unit Managers will review new orders and verify medications have been obtained, follow up with pharmacy and or the attending physician for new instructions when medications are not available and report finding to the Director of Nursing Services or Assistant Director of Nursing Services. The Medication and Treatment Administration records and physician orders will be reviewed at the Clinical Start up for completion and follow up. **4.) The Facility will monitor its performance to make sure solutions are sustained.** The Reviews will be analyzed and discussed at the Facility Quality Assurance and Performance Assessment meeting monthly for 3 months for discussion, analysis and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 309	Continued From page 50 9. For Resident # 16, the facility staff failed to clarify an order for Accu-Check blood sugar to include parameters and did not notify the physician of elevated blood sugar results of 562 on 2/25/2016. The findings included: 1. For Resident #29, the facility staff failed to administer Enoxaparin (a blood thinner) and Ciprofloxacin (an antibiotic) per physician's orders. Resident #29, a male, was admitted to the facility 7/17/15 and died at the facility 1/4/16. His diagnoses included schizophrenia, non-displaced second and sixth cervical vertebrae, hypertension, adult failure to thrive, conjunctivitis, Alzheimer's, urinary tract infection, anxiety disorder, major depressive disorder, ptosis, gastroesophageal reflux disease, and tachycardia. Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/16/15 was coded as a significant change assessment. He was coded as having no memory deficits and was able to make his own daily life decisions. He was coded as needing extensive to total assistance of one to two staff members to perform his activities of daily living. Review of Resident #29's clinical record revealed he had experienced a fall at the facility 12/4/15	F 309		

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F 309	Continued From page 51 and was sent to the hospital for treatment. Resident #29 was readmitted to the facility on 12/11/15. Included with his admission orders was an order for "12/11/15 Enoxaparin Sodium 30 mg (milligram)/0.3 ml (milliliter) Inject 1 application subcutaneously every 12 hours for DVT (deep vein thrombosis)." A subcutaneous injection is an injection made right under the skin and into the subcutaneous tissue. An accompanying entry was placed on the eMAR (electronic medication administration record) for the medication to be administered twice daily at 9 a.m. and 9 p.m. Review of the eMAR revealed Enoxaparin was administered 12/11/15 at 9 p.m. On 12/12/15 the medication was not administered at either time with a note on the eMAR referring the reader to the nursing notes. In the nursing notes, entries were made indicating the medication was not administered as it was not available from the pharmacy. When interviewed RN (registered nurse) B stated 3/4/16 at 10:42 a.m., she could not determine why Enoxaparin had not been administered as it was available from the emergency supply of medications. Review of the emergency medication supply listing indicated the medication was in the emergency supply and would have been available for use. RN B stated the nurses are aware of the supply and how to access the supply for Resident use. www.nlm.nih.gov provides guidance for the administration of Enoxaparin: "Enoxaparin is used to prevent blood clots in the leg in patients who are on bedrest or who are having hip replacement, knee replacement, or	F 309		

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F 309	Continued From page 52 stomach surgery. It is used in combination with aspirin to prevent complications from angina (chest pain) and heart attacks. It is also used in combination with warfarin to treat blood clots in the leg. Enoxaparin is in a class of medications called low molecular weight heparins. It works by stopping the formation of substances that cause clots. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use enoxaparin exactly as directed. Do not inject more or less of it or inject it more often than prescribed by your doctor. Continue to use enoxaparin even if you feel well. Do not stop taking enoxaparin without talking to your doctor." Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "11). If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit." Additionally, another order was included on the admission orders obtained for Resident #29 by the facility staff and included: "12/11/15 Cipro tablet (Ciprofloxacin HCL) Give 1 tablet by mouth ever 12 hours for UTI (urinary tract infection) for three days." An entry was placed on the eMAR for Resident #29 to be administered Cipro twice daily beginning at 9 p.m. on 12/11/15. Nurses' initials indicated the medication was administered on 12/11/15 at 9 p.m. and 12/12/15 at 9 a.m. The entry was discontinued and reentered on	F 309		

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F 309	Continued From page 53 12/12/15 for the same dosage and timing, "Cipro 500 mg Give 1 tablet by mouth every 12 hours for UTI for 3 days." Nurses' initials were entered indicating Cipro was administered twice daily from 12/12/15 at 9 p.m. through 9/15/15 at 9 a.m. Calculation of the doses administered indicated Cipro 500 mg was administered twice daily for four days not the three days as ordered by the physician. Review of the clinical record revealed no new physician's order had been received 12/12/15 regarding the administration of Ciprofloxacin. When interviewed 3/4/16 at 10:42 a.m., RN B was unable to determine why the order was entered the second time resulting in Resident 29 receiving an inaccurate amount of Cipro. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "2). Medications are administered in accordance with written orders of the prescriber." Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." Guidance for administration of Ciprofloxacin is provided at www.nlm.nih.gov: The length of your treatment depends on the type of infection you have. Your doctor will tell you how long to take ciprofloxacin. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take ciprofloxacin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor." The acting administrator, ADON (assistant	F 309		

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F 309	Continued From page 54 director of nursing) and corporate consultant were informed of the failure of the staff to administer Enoxaparin and Ciprofloxacin per physician's orders, 3/4/16 at 12:15 p.m. 2. For Resident #1, the facility staff failed to administer treatments as ordered by the physician, Resident #1, a female, was admitted to the facility 6/13/13. Her diagnoses included sacral pressure ulcer, aphasia, contracture, Alzheimer's dementia, and hypertension. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/28/15 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total assistance of one to two staff members to perform her activities of daily living. Resident #1 was also coded as having one stage IV pressure ulcer. Review of Resident #1's clinical record revealed the following treatments were not administered: MA 65 every shift for pressure ulcer (specialty low air loss mattress): 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 Day shift, 2/8/16 day shift Apply Sure prep pad to left lateral foot every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift Bilateral 1/2 side rails to assist with bed mobility	F 309		

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	495252	A. BUILDING _____ B. WING _____	C 03/04/2016

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F 313	Continued From page 70 one resident (Resident #4) in a survey sample of 31 residents was provided his glasses for use. Resident #4 did not have his glasses on during the days of the survey. The findings included: Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The most recent MDS (minimum data set) dated 2/3/16 did not code the resident's BIMS (brief interview of mental status) score. The previous MDS had coded the BIMS score as "7" out of a possible 15 or moderate cognitive impairment. The MDS coded the resident as requiring total assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. The MDS coded the resident required glasses for use. On 3/2/16 at 8:40 AM, Resident #4 was observed in the bed with the TV on. No glasses were in place. On 3/2/16 at 10:00 AM, the resident was observed for wound care. His glasses were not on. On 3/3/16 at 9:10 AM, CNA (certified nursing assistant-C) was questioned as to Resident #4's morning care. She stated, "I give a bath, do teeth, put barrier protective cream and put him in a chair. He goes to rehab and I put him to bed after. He likes to watch TV." On 3/3/16 at 11:15 AM, Resident #4 was observed in the therapy room, without his glasses. On 3/3/16 at 1:45 PM, CNA (C) was asked about Resident #4's glasses. She stated, "I did not put them on." Review of the Resident #4's care plan dated 2/18/16 regarding 'Risk for Impaired Vision related to glaucoma, history of cataracts , wearing	F 313	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Field Services Clinical Director will In-service the Director of Nursing Services on following Plans of Care and Care Card Use of appropriate devices to maintain vision. Nursing Staff will be in-serviced by 04/01/16 by the Director of Nursing or Assistant Director of Nursing to follow the plan of care and care card for use of appropriate devices to maintain vision. New orders for assistive devices will be reviewed in clinical start up. Social Worker and or Social Worker Assistant will follow up on all grievances on missing devices for vision. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits will be conducted 2 times per week for 3 months by the Social Worker or Social Worker Assistant of residents with assistive devices for vision to ensure compliance and these audits will be brought through the monthly Quality Assurance and Process Improvement meeting for further review and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 313	Continued From page 71 glasses and diagnosis of diabetes, " revealed the following: "Assist with placement and cleaning with glasses as needed." On 3/3/16 at 4:15 PM, the facility Administrator and nurse consultant were notified of the above findings.	F 313		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to provide a safe environment for two residents (Resident # 31 and Resident # 21) in a survey sample of 31 residents. 1. For Resident # 31, the facility staff failed to provide a hazard free environment as a bottle of hydrogen peroxide was found at the bedside. http://www.webmd.com/drugs/2/drug-76035/hydrogen-peroxide/details "Is a mild anitseptic used on the skin..." 2. For Resident #21, the facility staff failed to maintain adequate supervision to prevent him from causing injury to Resident #26. Resident	F 323	**F 323** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The bottle of hydrogen peroxide was immediately removed from Resident # 31 room on 03/03/16. Resident #21 had been discharged from the facility on 07/09/15 **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents had the potential to be affected.	

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F 323	Continued From page 72 #21 was on one to one supervision when he wandered into Resident #26's room and caused injury to his right arm and wrist. Findings included: 1. For Resident # 31, the facility staff failed to provide a hazard free environment as a bottle of peroxide was found at the bedside. Resident # 31 was a 91 year old female admitted to the facility with diagnoses of but not limited to Dementia, GERD (Gastroesophageal Reflux Disease), Diabetes, Chronic Kidney Disease, Anxiety, Psychosis, Major Depressive Disorder and Overactive Bladder. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/28/2016. The MDS coded Resident #31 with BIMS (Brief Interview for Mental Status) of 9/15 indicating cognitive status as mild- moderately impaired; Resident # 31 was coded as needing limited to extensive assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident # 31 was coded as independent and needing only set up. Resident # 31 was coded as being able to hear, speak, understand, and be understood. On 3/3/2016 at 3:30 PM, a bottle of Hydrogen Peroxide was observed on the bedside table of Resident # 31. Two nurses were making rounds for the change of shift. LPN D (Licensed Practical Nurse) worked the day shift and was giving report to LPN H who was scheduled to work the 3-11 shift. When both nurses entered the room, the surveyor asked if residents were allowed to have	F 323	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** A facility sweep was conducted by 03/25/16 to ensure that there were no hazardous materials left in resident rooms or common areas. The Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor will educate Staff on maintaining close proximity to residents on 1:1 and calling for assistance when not able to maintain close proximity. **4.) The Facility will monitor its performance to make sure solutions are sustained.** The Executive Director or Director of Nursing or Assistant Director of Nursing or RN Supervisor will in-service staff by 04/01/16 on the need to keep resident rooms and areas free from hazardous materials, Residents who require supervision to maintain the safety of others will be supervised based on individual occurrences and needs such as 1:1, Q 15 minute checks. Audits of rooms and common areas will be conducted by the Departmental Management Staff through our non clinical Rounds. Audits will be reviewed and discussed and analyzed at our Monthly QAPI meetings for 3 months for recommendation and follow up. Ongoing review of residents on 1:1 will be discussed and reviewed in QAPI. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 323	Continued From page 73	F 323		

medications or treatments by the bedside. Both nurses said medications and treatments were not allowed at the bedside. LPN D stated she had not noticed the bottle of Peroxide on the bedside table during her 7-3 shift. LPN D took the bottle of Peroxide off of the bedside table. LPN H stated she was just coming to work and had not seen the bottle of Peroxide on the bedside table before.

Residents were observed wandering in and out of rooms on both units during the survey.

During the end of day debrief on 3/3/2016 at approximately 4:30 PM, the administrator and Corporate consultants were informed that a bottle of Hydrogen Peroxide was found on the bedside table of Resident # 31.

No further information was provided.

2. For Resident #21, the facility staff failed to maintain adequate supervision to prevent him from causing injury to Resident #26. Resident #21 was on one to one supervision when he wandered into Resident #26's room and caused injury to his right arm and wrist.

Resident #26, a male, was initially admitted to the facility 7/1/15. His diagnoses included lung cancer, coronary artery disease, hypertension, and senile dementia.

Resident #21's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/8/15 was coded a five day assessment. Resident #21 was coded as having a BIMS (Brief Interview of Mental Status) score of 0, severe impairment. He was coded as having clear comprehension for understanding others and as

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F 323	Continued From page 74 having the ability to be understood by others. He was also coded as needing limited assistance of one staff member to perform his activities of daily living with the exception of eating. For eating he was coded as needing set up assistance of one staff member. Resident #21 was coded for being ambulatory with limited staff assistance. Further review of the MDS revealed Resident #21 was coded for the following behaviors four out of six days during the assessment period: "a. Rejection of care. b. Wandering. c. Physical behavior symptoms toward others. d. Verbal symptoms directed toward others. e. Other behavioral symptoms not directed toward others." A FRI (facility reported incident) submitted by the facility was reviewed. The incident occurred on 7/7/15 at which time Resident #21 entered Resident #26's room and grabbed his hand. The investigation revealed Resident #21 was on one to one supervision when the incident occurred and that it took two staff members to get Resident #21 to let go of Resident #26. Resident #26 was admitted to the facility on 3/10/14. His diagnoses included anxiety, coronary artery disease, hypertension, non-Alzheimer's dementia, depression and contact dermatitis. Resident #26's assessment at the time of the incident was a quarterly MDS with an ARD of 6/22/15. Resident #26 was coded as having a BIMS (Brief Interview of Mental Status) score of	F 323		

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F 323	Continued From page 75 5, severe impairment. He was coded as having clear comprehension for understanding others and as having the ability to be understood by others. He was also coded as requiring limited assistance of one staff member to perform his ADLs. Resident #26 was coded for being ambulatory with limited staff assistance. Resident #26 was coded as exhibiting no behavioral symptoms during this assessment period. Resident #26 was observed in his room on 3/2/16 at 5:45 p.m. Resident #21 did not recall the incident that occurred on 7/7/15. Resident #26's roommate was observed pacing in the room during the time of this observation. Resident #21 stated, "Yea, he walks around a lot but he knows not to mess with my stuff." Resident #21's clinical record revealed he exhibited wandering behaviors and attempts to exit the facility on the second day of admission into the facility, 7/2/15. According to the nurses' notes, Resident #26 was not adjusting well to the facility, was combative and was wandering in and out of residents' rooms. On 7/3/15 Resident #26 was noted as requiring frequent monitoring and had a wanderguard in place. On 7/5/15 Resident #26 exited the facility and the police were contacted to re-direct him into the facility. Resident #26 was sent out to the emergency room for psych evaluation. On 7/6/15 Resident #26 returned to the facility with one on one staff supervision. A behavior charting note, dated 7/7/15 read, "Resident wandered into another resident room. Resident was looking at the resident pictures when the other resident got mad and latched out	F 323		

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F 323	Continued From page 76 at him. Resident in turned grabbed the other resident right hand and arm. Causing the other resident to receive 3 skin tears to right hand and a bruise to right upper arm." On 3/3/16 at 11:40 a.m., a telephone interview was conducted with CNA (certified nursing assistant) B, the staff member providing one on one supervision at the time of the incident. CNA B said the incident occurred on the evening shift and she was walking with Resident #21 when he entered Resident #26's room. CNA B stated, "I followed him into the room and asked him to come out and he would not come out. He went over to look at (his name) Resident #21's pictures. That's when Resident #21 reached out toward him and Resident #26 grabbed his wrist" CNA B said she initially did not call for staff to assist her in getting him out of the room and that after she got Resident #21 to release Resident #26's hand, she was able to re-direct Resident #21 out of the room. On 3/6/16 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) G, the unit manager. LPN G said she was not working at the time of the incident but she said she was very familiar with both residents. LPN G said Resident #21 was well built and very fast. The administrator and corporate consultants were advised of the failure of the staff to keep Resident #26 safe from Resident #21's aggressive behavior, 3/4/16 at 2:15 p.m. COMPLAINT DEFICIENCY	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328	**F 328** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The Oxygen tanks were immediately removed from Resident # 7 room on 03/01/16 upon discovery. Resident #4 oxygen tubing and humidifier were changed on 03/02/16 and Resident #7 oxygen tubing and humidifier were changed on 03/03/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents on oxygen have the potential to be affected. An Audit of residents with oxygen humidifiers was completed by 03/03/16 and all tubing and humidifiers were changed as needed.	

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F 328	Continued From page 77 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility documentation and clinical record review, the facility staff failed for two residents, (Resident #7 and Resident #4) in a survey sample of 31 residents, to ensure physician ordered oxygen was provided. 1. For Resident #7, oxygen tanks were not stored safely and the oxygen tubing and humidifier bottle was not changed for 21 days. 2. For Resident #4, the nebulizer tubing and humidifier bottle was not changed for 20 days. The findings included: 1. Resident #7 was admitted to the facility on 6/30/14. Diagnoses included COPD (chronic obstructive pulmonary disease), anemia, and schizophrenia. The most recent MDS (minimum data set) dated 2/2/16 coded the resident's BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. The	F 328	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Director of Nursing or Assistant Director of nursing will in-service the Nursing and Central Supply staff responsible for and on the need to change oxygen tubing, humidifiers and nebulizer tubing weekly by 04/01/16. This in-service will include the safe storage and handling of oxygen. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits will be conducted 3 times per week for 3 months by the Director of Nursing or Assistant Director of Nursing or Charge Nurses to ensure compliance with oxygen protocols. These audits will be brought through the monthly QAPI meetings for further review and recommendations and action. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 328	Continued From page 78 MDS coded the resident as requiring no or supervision assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. The resident was coded as having received oxygen therapy in the last seven 7 days. On 3/1/16 at 2:45 PM, during the initial tour, Resident #7 was observed in her room. Two small oxygen cylinders were on the floor, unsecured, beside the closet. Oxygen tubing and the humidifier bottle was dated 2/10/16. Resident #7 stated, "I asked them to take them out, they have been rolling around on the floor." On 3/1/16 at 3:30 PM, the oxygen amounts in the tanks were checked by RN (registered nurse-D), one was full at 2000 Pounds and one was empty. RN (D) stated, "It should not be stored like that, it should be stored in a crate in the O2 (oxygen) room." RN (D) proceeded to remove the tanks from the room and placed them in the oxygen storage room at 3:35 PM. On 3/2/16 at 5:10 PM, the resident was out of the room. The oxygen concentrator tubing and humidifier bottle was dated 2/10/16. On 3/2/16 at 9:20 AM, the oxygen tubing and humidifier bottle had not been changed. The resident stated that she used her concentrator at night and the oxygen cylinders during the day when out of the room. On 3/2/16 at 2:55 PM, LPN (licensed practical nurse (C) was taken to the room. LPN (C) stated, "I don't know who is changing the oxygen tubing, it is supposed to be changed every week." LPN (C) then changed the tubing and humidifier bottle.	F 328		

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F 328	Continued From page 79 COPD.about.com stated the following: "While manufacturers recommend changing your cannula between once a week and once a month, the most important factor in deciding when to change your cannula is your health. You must change the cannula any time that you have been sick or may be coming down with something, to keep bacteria in check." Further review of the clinical record revealed the resident has been treated twice with oral antibiotics (2/18/16 and 3/1/16) for an upper respiratory infection. 2. For Resident #4, the nebulizer tubing and humidifier bottle was not changed for 20 days. Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The most recent MDS (minimum data set) dated 2/3/16 did not code the resident's BIMS (brief interview of mental status) score nor had his cognitive status been assessed, but contained only dashes. The previous MDS had coded the BIMS score as "7" out of a possible 15 or moderate cognitive impairment. The MDS coded the resident as requiring total assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. On 3/1/16 at 5:05 PM, Resident #4 was observed in the bed with oxygen infusing at 2 liters per minute by nasal cannula. The humidifier bottle was dated 2/17/16 and nebulizer tubing was dated 2/10/16. On 3/2/16 at 8:40 AM, nebulizer and humidifier	F 328		

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F 328	Continued From page 80 bottle were changed with the date of 3/2/16. Review of the policy for oxygen administration was reviewed. It contained the following: "Oxygen cylinder on stand." On 3/2/16 at 4:50 PM, the DON (director of nursing) stated the "tubing is to be changed weekly." On 3/2/16 at 5:00 PM, the Administrator and DON were notified of above findings.	F 328		
F 329 SS=D	COMPLAINT DEFICIENCY 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 5 Physician was notified of the administration of blood pressure medication being given without obtaining a blood pressure prior to administration from 02/27/16 thru 03/02/16 with no new orders. The blood pressure readings were added to the MAR on 03/03/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Licensed nursing staff will be in-serviced by the Director of Nursing or Assistant Director of Nursing on Medication Administration Guidelines including the documentation of any pre-assessment data that is ordered by the physician.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

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F 329	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure one Resident (Resident #5) in a survey sample of 31 Residents was free from unnecessary medication. For Resident #5, the facility staff failed to obtain blood pressures to determine if Lisinopril needed to be administered. The findings included: Resident #5, a male, was admitted to the facility 2/26/16. His diagnoses included sepsis, hypothyroidism, hyperlipidemia, seizure, Parkinson's, depression, hypertension, pulmonary embolism, gastrointestinal bleed, pneumonitis, influenza, and cerebrovascular accident. Resident #5 had not been at the facility long enough to have an MDS completed. Review of the admitting nursing assessment revealed he had been assessed as having memory deficits and required assistance with making life decisions. He was also assessed as requiring total assistance with his activities of daily living. He was documented as having a stage II pressure ulcer on his sacrum. Resident #5 was observed 3/2/16 at 9:05 a.m. and 3/3/16 at 5:02 p.m. At both observations, he was lying on his side with the head of the bed	F 329	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Physician orders will be reviewed in clinical start up to ensure that the orders are complete and that pre-assessment data is present as ordered. **4.) The Facility will monitor its performance to make sure solutions are sustained.** The results of these reviews will be presented and discussed in QAPI for 3 months for analysis and review and recommendations/action steps. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 329	Continued From page 82 elevated. Resident #5 was awake however non verbal. Review of Resident #5's clinical record revealed an order that was included with the admission orders, "2/26/16 Lisinopril tablet Give 10 mg (milligram) via PEG-Tube one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold if SBP (systolic blood pressure) < (less than) 100." A peg tube is soft flexible tube surgically inserted through the abdominal wall into the stomach. The tube is utilized to administer medications, fluid, and nutrition for a Resident that is unable to swallow. An accompanying entry on the eMAR (electronic medication administration record) indicated Lisinopril 10 mg was administered daily from 2/26/15 through 3/2/16. No blood pressure documentation was evident indicating Resident #5's blood pressure had been obtained prior to the administration of Lisinopril to determine if the systolic blood pressure was less than 100 mm/hg (millimeters of mercury). The systolic blood pressure is the upper number of the blood pressure indicating the pressure in the blood vessels when the heart beats. A thorough review of the clinical record revealed Resident #5's blood pressure had been obtained twice during the time period from 2/26/16 through 3/2/16, however the blood pressures could not be determined to have been obtained prior to the administration of Lisinopril. Registered Nurse (RN) B, after reviewing the lack of blood pressures within the clinical record stated, 3/2/16 at 4 p.m., the nurse entering the order into the computer failed to enter the order	F 329		

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F 329	Continued From page 83 properly, not entering a space for the blood pressure reading. RN B stated only two blood pressures had been obtained since Resident #5 had been admitted to the facility and all new admissions should, at a minimum, have their blood pressure obtained every shift for the first three days. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "2). Medications are administered in accordance with written orders of the prescriber." Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." Same source, page. 709, "The nurse is also responsible for documenting any preassessment data required of certain drugs, such as a blood pressure measurement for antihypertensive medications, or laboratory values, as in the case of Dilantin before giving the drug." The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to ensure Resident #5's blood pressure was obtained to determine if Lisinopril 10 mg needed to be administered, 3/4/16 at 12:15 p.m.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that --	F 334	**F 334** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 20 was offered the Flu Vaccine and refused the Vaccine.	

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F 334	Continued From page 84 (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	**2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** An Audit of residents will be completed by 04/01/16 0f all residents to determine residents who gave consent to receive Flu Vaccine. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Director of Nursing or Assistant Director of Nursing or RN Supervisor will in-service Nursing Staff and Admissions by 04/01/16 pm the need to complete the Immunization Consent Form. Those identified with signed consent will be monitored by Unit managers for administration of the vaccine. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Admission Charts will be reviewed in Clinical Start up for Immunization Status by the Director of Nursing and or Assistant Director of Nursing to ensure vaccines are given per consent and as ordered. The Director of Nursing and Assistant Director of Nursing will review and report findings to QAPI Monthly for action and follow up based on analysis and findings. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 334	Continued From page 85 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one Resident (Resident #20) in a survey sample of 31 Residents was administered the flu vaccine. For Resident #20, while consent was given, there was no evidence the flu vaccine was administered. The findings included: Resident #20, a female, was admitted to the facility 11/1/13. Her diagnoses included Parkinson's, anxiety, chronic obstructive	F 334		

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F 334	Continued From page 86 pulmonary disease, anemia, hyperlipidemia, cerebral pseudo sclerosis, epidemic vertigo, dementia, unspecified psychosis, paranoid delusions, osteoarthritis, and congestive heart failure. Resident #20's most recent MDS (minimum data set) with an (assessment reference date)ARD of 12/1/15 was coded as a quarterly assessment. Resident #20 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #20 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident #20 was coded as requiring standby assistance of one staff member. Resident #20 was coded as not having received the flu vaccine, with "9" entered (none of the above) as the reason the vaccine was not administered. Review of Resident #20's clinical record revealed Resident #20's son gave consent for the vaccine to be administered in September, 2015. A thorough review of the clinical record, including the nursing notes, immunization section, and eMAR revealed no evidence the flu vaccine had been administered. LPN (licensed practical nurse) G, the unit manager, said 3/4/16 at 10:40 a.m., she had investigated the clinical record for evidence Resident #20 had received the flu vaccine. LPN G stated there was no indication the vaccine had been administered. The nurse responsible for the facility's immunization program in September, 2015 was no longer employed at the facility and there was no way to determine if the vaccine had been administered, according to LPN G.	F 334		

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F 334	Continued From page 87 The acting administrator, ADON (assistant director of nursing) and corporate consultant were informed of the failure of the staff to administer the flu vaccine to Resident #20 during the 2015 flu season, 3/4/16 at 12:15 p.m.	F 334		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to implement physician ordered assistive devices to enhance independence in eating for one Resident (Resident #8) in a survey sample of 31 Residents. For Resident #8, physician ordered individual bowls for food which were not implemented. The findings included: Resident #8, a female, was initially admitted to the facility 9/10/08 and readmitted after a hospitalization 8/4/10. Her diagnoses included hypothyroidism, dementia, major depressive disorder, unspecified psychosis, anxiety disorder, hypertension, arteriosclerotic cardiovascular disease, and gastroesophageal reflux disease. Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of	F 369	**F 369** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 8 Care Plan and Care Card were updated to reflect the order for having food placed in individual bowls. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents who use adaptive equipment have the potential to be affected and an audit was conducted by the Dietary Services Manager by 03/21/16 of residents with orders for adaptive equipment to ensure that they were reflected on the Care Plan, Care Card and Dietary Matrix. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Dietary Staff were in-serviced by the Dietary Services Manager by 03/25/16 that Physicians Orders for adaptive equipment must be followed. New orders will be reviewed in clinical start up and updated as needed on Care Plans and Care Cards by Unit Managers... Licensed Nursing Staff will be in-serviced by 04/01/16 on the need to utilize Dietary Communication Slips/Forms by the Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor.	

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F 369	Continued From page 88 11/24/15 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required extensive to total assistance of one staff member to perform her activities of daily living. Resident #8 was observed 3/2/16 at 9 a.m. She was lying in bed sleeping. A staff member brought in Resident #8's breakfast tray and woke her up for breakfast. On the tray was fortified oatmeal in a bowl. On a regular plate was sausage gravy and a waffle. Resident #8 was also observed in the restorative dining room, 3/2/16 at 12:10 p.m. She was sitting at a table and the staff brought her plate with her lunch. The plate contained meat and potatoes with gravy. In a small separate bowl was broccoli. She had thickened liquids to drink. Except for the oatmeal and broccoli, the foods were not in individual bowls. Review of Resident #8's clinical record revealed the following physician's order, "8/19/14 Pt (patient) to have food placed in individual bowls at all meals in order to increase independence with self feeding." The order was on the most recently signed "Order Summary Report" dated as signed 2/17/16. Review of Resident #8's comprehensive care plan revealed a care plan had been developed 3/18/15 for "Inadequate Oral Food/Beverage intake due to Dementia. Food and beverage intake less than required. Resident is now receiving appetite stimulant and PO (by mouth) intake has improved. Included in the "Interventions" were:	F 369	**4.) The Facility will monitor its performance to make sure solutions are sustained.** Physician Order Audits for adaptive equipment will be conducted by the Dietary Services Manager or Unit Managers weekly for 1 month then monthly for 3 months to ensure compliance and the results of these audits will be brought through the monthly QAPI meeting for discussion and further analysis and recommendations and follow up / action steps. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 369	Continued From page 89 *Administer supplemental medications as ordered *Clothing protector as desired *Diet as ordered *Identify the food and placement on plate/table during meals *Invite to food related activities *Medication review by pharmacist *Monitor for S/Sx (signs and symptoms) of depression *Monitor meal consumption daily *Monitoring though Weight Management Committee *Monthly weights *Notify Physician and family/responsible party of weight change *Obtain and update food/beverage preferences *Provide assistance with meals *Screen/evaluation by rehab services prn (as needed) *Supplements and/or snacks as ordered" A thorough review of Resident #8's clinical record revealed no evidence the use of separate bowls had been care planned. When interviewed, the DON (director of nursing) stated 3/2/16 at 3:30 p.m., the staff utilized the care plan to know how to meet Resident's needs. She further stated the CNA (certified nursing assistants) had a "Resident Kardex" that provided guidance to them for Resident needs. The "Resident Kardex" for Resident #8 was reviewed. While her diet was listed and that she ate in the "activity room for lunch and dinner" no information was provided that Resident #8 was to have individual bowls for all of her food. Other P was interviewed, 3/4/16 at 10:10 a.m.	F 369		

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F 369	Continued From page 90 Other P was in the dietary department and stated that when any order is obtained regarding dietary needs, nursing was to fill out a communication form to inform dietary of whatever the need is. Other P said she was unaware of any order for Resident #8 to have separate bowls for her food. A copy of the information from "Momentum Meal Matrix" was provided. That was the computer system utilized by dietary to assist dietary with Resident 8's needs. While on the copy that was presented, the use of individual bowls was evident, Other P stated she had updated Resident #8's information. Prior to be updated, Other P stated there was no information regarding the use of individual bowls for Resident #8. The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to ensure the use of individual bowls for all foods to foster independence in eating was implemented 3/4/16 at 12:15 p.m.	F 369		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	**F 431** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The facility medication rooms, medication carts and medication refrigerators were checked for any expired or undated medications, and then they were removed and disposed of per facility protocol by 03/04/16.	

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F 431	Continued From page 91 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to date and store medications per manufacturer's recommendations and failed to ensure discharged Resident medications were not available for administration on two of two units. 1. On Unit 1, in medication cart one, an opened and accessed vial of Novolog insulin was dated as being opened on 11/25/15; 2. On Unit 2, in medication cart 1, an opened and accessed vial of Humalog insulin was utilized for Resident administration with no date evident	F 431	**2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents of the facility had the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Field Services Clinical Director will in-service the Director of Nursing on monitoring medication storage. Licensed Nurses will be in-serviced by 04/01/16 by the Director of Nursing, or Assistant Director of Nursing or RN Supervisor on Medication Destruction policy and proper storage and labeling of medications. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits will be conducted 3 times per week for 3 months by the Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor of the Medication Rooms, Medication Refrigerators and medication carts to ensure compliance. These findings will be brought through the monthly QAPI meeting for further review and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 431	Continued From page 92 when the vial was accessed; and 3. In the medication refrigerator on Unit 2, a cardboard container (identified as a hospice comfort kit) was stored in the freezer, covered with a thick layer of ice and the medication was frozen. The Resident was identified as having died 7/12/15. The findings included: During observation of the medication rooms and carts, the medication carts on Unit 1 were observed 3/3/16 beginning at 10:40 a.m. Within the drawer on medication cart 1, was observed an opened and accessed vial of Novolog insulin. The insulin was dated as having been opened and accessed 11/25/15. The Resident whose name was on the box was still a Resident at the facility. When interviewed, LPN (licensed practical nurse) A stated 3/3/16 at 10:40 a.m. she thought the vial of insulin was good for 30 days after being opened. LPN A stated she did not give the Resident insulin on her shift so she was not sure about the dating on the vial, however she said it was over the date it was good for. LPN A thought there was a sheet to indicate how long the Insulins were good for once being opened. Guidance was provided at www.novolog.com: "How should I store NovoLog®? Do not freeze NovoLog®. Do not use NovoLog® if it has been frozen.	F 431		

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F 431	Continued From page 93 · Keep NovoLog® away from heat or light. · Store opened and unopened NovoLog® vials in the refrigerator at 36°F to 46°F (2°C to 8°C). Opened NovoLog® vials can also be stored out of the refrigerator below 86°F (30°C). · Unopened vials may be used until the expiration date printed on the label, if they are kept in the refrigerator. · Opened NovoLog® vials should be thrown away after 28 days, even if they still have insulin left in them." Observation of the Unit 2 medication carts revealed in cart 1 was a vial of open Humalog insulin. The vial indicated it had been obtained from the emergency supply. No date was on the vial to indicate when the vial had been opened and accessed. LPN D observed the vial and stated 3/3/16 at 10;48 A.M., the vial should be dated when opened and accessed. LPN D stated she had not administered insulin from the vial and was unable to determine when the vial had been accessed. Guidance was provided at www.humalog.com for storage of Humalog insulin: "How should I store HUMALOG? All unopened HUMALOG vials: Store all unopened vials in the refrigerator. Do not freeze. Do not use if it has been frozen. Keep away from heat and out of direct light. Unopened vials can be used until the expiration date on the carton and label, if they have been stored in the refrigerator.	F 431		

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F 431	Continued From page 94 Unopened vials should be thrown away after 28 days, if they are stored at room temperature. After HUMALOG vials have been opened: Store opened vials in the refrigerator or at room temperature below 86°F (30°C) for up to 28 days. Keep vials away from heat and out of direct light. Throw away all opened vials after 28 days of use, even if there is insulin left in the vial. " Guidance the nursing staff utilized to determine how long insulin was good for once opened and accessed was asked for on 3/3/16 at the end of day meeting. By the end of the survey, no guidance was provided. The medication room on Unit 2 was observed beginning at 10:48 on 3/3/16. Located within the medication refrigerator, in the freezer section, was a cardboard box covered with a thick layer of ice. The box was unable to be removed due to the ice, so LPN C tore the box open and removed the medications within the box. LPN C stated the box appeared to be a hospice comfort kit for a Resident that had died at the facility 7/12/15. The medications within the box were: 1 bottle of Morphine sulfate drops-a controlled substance, a notation on the bottle indicated to discard after 9/10/15 1 bottle of Atropine drops- a notation was on the bottle to discard after 9/20/15 1 bottle of Haldol solution, very little in the bottle- a notation on the bottle to discard after 7/21/16 Bag of Biscodyl suppositories- to be discarded after 7/2/16 Bag of Acetaminophen suppositories- to be discarded after 7/2/16 bag of Ativan tablets to be discarded after 7/2/16-.	F 431		

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F 431	Continued From page 95 All of the liquid and suppository medication were frozen. LPN C stated the hospice provider would discard the comfort kit at the time of the Resident's death or discharge if "someone thought to get it and give it to them." LPN C stated the facility would discard the medication if hospice did not take it. Review of the facility's policy entitled "Controlled Substance Disposal" included: "C. All controlled substances remaining in the facility after a resident has been discharged, or the order is discontinued, are disposed of: 1). In the facility by the (administrator), director of nursing and/or consultant pharmacist (or others as allowed by state law) OR 2). By returning to the Drug Enforcement Administration (DEA);OR 3). By retaining for destruction by an agent of the DEA ; OR 4). By sending to the appropriate state agency/reverse distributor, as directed by state laws, regulation, and/or the DEA." Also, review of the policy entitled "Medication Destruction" covered destruction of non-controlled medications: "A. Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed. Destruction of Medications by Facility A. All discontinued medication will be immediately located and removed from the	F 431		

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F 431	Continued From page 96 resident's active medication storage area and stored in a separate locked area for up to 90 day or as required by applicable law, and then destroyed by a manner in accordance with applicable state and federal laws. E. The facility will place all discontinued or out-dated medications in a designated, secure location, to be used only for discontinued and/or expired medications. G. Discontinued medications and/or out-dated medications will be disposed of by the facility within 90 days of the date the medication was discontinued , or by applicable law." Additionally storage of medications by medication: Morphine Sulfate at www.drugs.com: "Storage Store at 20° to 25°C (68° to 77°F). [See USP Controlled Room Temperature.] PROTECT FROM MOISTURE." Haldol solution at www.drugs.com: "Store at 20°-25°C (68°-77°F) [See USP Controlled Room Temperature] Protect from freezing. Protect from light." Biscodyl Suppositories at www.dailymed.nlm.nih.gov: "Storage Store at 20-25 C (68-77 F)" Acetaminophen suppositories at www.medicinenet.com:	F 431		

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F 431	Continued From page 97 "STORAGE: Store at room temperature away from heat. If the room temperature is above 80 degrees F (27 degrees C), then store the medication in the refrigerator. Do not freeze." Ativan tablets at www.drugs.com: "Proper storage of lorazepam: Store lorazepam at room temperature, between 59 and 86 degrees F (15 and 30 degrees C). Store away from heat, moisture, and light. " The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to ensure Insulins were dated when opened and accessed, were discarded after the appropriate time frame, and hospice medications were stored appropriately and discarded in a timely manner after discharge, 3/4/16 at 12:15 p.m.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	**F 441** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #3 isolation precautions were discontinued by the physician on 03/02/16. There was no evidence found of any cross contamination. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents on isolation precautions have the potential to be affected. There are currently no residents on isolation precautions.	

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F 441	Continued From page 98 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed for 1 resident (Resident #3) of 31 residents in the survey to implement an effective infection control program. 1. For Resident #3, the facility staff failed to implement contact isolation precautions. 2. For Resident #3, the facility staff failed to perform proper hand hygiene, and failed to implement contact precautions. The findings included: Resident #3, a 90 year old, was admitted to the facility on 4/11/11. Her diagnoses included colon	F 441	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Staff will be in-serviced by the Assistant Director of Nursing or RN Nurse Supervisor on the Isolation contact precautions-Categories of Transmission-Based Precautions policy and the Handwashing/Hand Hygiene policy by 04/01/16. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits of Hand Hygiene and Isolation Precautions will be conducted by the Assistant Director of Nursing Services or RN Nurse Supervisor 3 times per week for 3 months. Findings/Results of audits will be communicated and reviewed in the monthly QAPI meeting for further review and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 441	Continued From page 99 cancer, diabetes, hypertension, degenerative joint disease and Methicillin-resistant Staphylococcus aureus (MRSA) in the right heel wound. Resident #3's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 12/8/15. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with her activities of daily living. On 3/2/16 at 9:05 a.m., Resident #3 was observed from the hallway sitting in her wheelchair just inside the door of her room. She was dressed and was wearing shoes. Resident #3 was asked if her foot was painful. She stated that she can feel the heel wound but it is not painful. On the outside of the door hung a blue bag with pockets. The bag held personal protective equipment (PPE), to include gloves, gowns, red bags, and masks. There was no sign on the door. At this time, a woman dressed in plain clothes washed and dried both of Resident #3's hands. The woman was not wearing gloves or a gown. She had direct skin to skin contact with Resident #3's hands. A certified nursing assistant (CNA) was in the hallway at the time and was asked to identify the woman with Resident #3. The CNA thought the woman was a volunteer activities staff. At 9:20 a.m., Registered Nurse B (RN B) was asked which resident in the room was on contact precautions. She stated that only A bed (Resident #3) was on precautions. At 9:25 a.m., a staff member was observed in the room. The	F 441		

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F 441	Continued From page 100 staff was gowned and gloved and providing care to the resident in B bed (who was not on precautions). The woman who had washed Resident #3's hands earlier was standing at the doorway at this time. The woman was asked if she was a volunteer. She stated no. The woman was asked what her role was at the facility. She stated that she was the sister of the resident in B bed. The woman pointed to the blue bag on the door and asked this surveyor if she was supposed to be using the supplies. The woman was instructed to ask one of the facility nursing staff. On 3/2/16 at 11:00 a.m., the unit manager, Licensed Practical Nurse G (LPN G), was asked what a person needed to do to enter a contact precaution room. LPN G stated that there is a sign on the door that directs a person to see the nursing staff. LPN G would then instruct that gown and gloves needed to be worn. She stated that gloves should be discarded in the room and hands washed prior to exiting. When asked who was expected to follow these instructions, LPN G stated that anyone entering the room. When asked if it was required that a sign be on the door, LPN G stated yes. On 3/2/16 at 11:10 a.m., one of the housekeeping staff (Other L) was asked about the PPE supplies hanging on the door. Other L stated that the supplies on the door were for the CNA's to use. When asked if she needed to use the supplies when she went in the room, Other L stated that she was required to wear gloves in every room. She stated that she was required to remove her gloves before exiting the room. Other L was asked two times if there was anything else she needed to do before she left the room. She	F 441		

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F 441	Continued From page 101	F 441		

stated no both times the question was asked. Other L did not mention the need to wash her hands before exiting the contact precaution room.

The infection control nurse, Registered Nurse A (RN A), was interviewed on 3/3/16 at 2:45 p.m. RN A was asked to describe how contact precautions were implemented. She stated that a blue bag with PPE was hung over the door. She stated that there was usually a sign on the door. When asked if the sign was required, RN B stated that the sign should be there. She stated that gown and gloves should be worn. When asked who needed to gown and glove, RN A stated that anyone taking care of the patient needed to gown and glove. When asked if that included visitors, RN A stated no. When asked if that included dietary staff, RN A stated that dietary staff do not go in the room. When asked if that included housekeeping staff, RN A stated that the housekeeping should gear up. RN A was asked to explain the importance of contact precautions. She stated that it was to prevent contamination, to prevent one person from getting an infection and taking it to someone else.

At the end of day meeting on 3/2/16, the acting Director of Nursing, the acting Administrator, and both corporate nurses were notified that there was no sign on Resident #3's door indicating she was on contact precautions. They were notified that a family member was observed washing Resident #3's hands without wearing PPE. They were notified that the housekeeping staff did not know which PPE to wear and did not know to wash her hands before exiting the room. They were notified that a CNA was wearing PPE to care for a resident who was not on precautions.

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F 441	Continued From page 102 No further information regarding Resident #3's contact precautions was provided. The facility policy titled "Isolation-Categories of Transmission-Based Precautions" was reviewed. Contact precautions were addressed on page 3. "1) Infections with multi-drug resistant organisms (determined on a case by case basis)" was listed under "a. Examples of infections requiring Contact Precautions". The policy read the following about gloves and handwashing "1)In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. 2)While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). 3) Remove gloves before leaving the room and perform hand hygiene. 4) After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room." The policy read the following about gowns "Wear a disposable gown upon entering the Contact Precautions room or cubicle." 2. On 3/1/16 at 4:15 P.M., an observation was made of the medication pass. Licensed Practical Nurse B was observed administering Artificial Tears to Resident #3's eyes. Resident #3 was on contact precautions for Methicillin Resistant Staphylococcus Aureus (an infection) in her foot. LPN B was not wearing a disposable gown while providing care for Resident #3. She wore gloves. After removing her gloves, she washed her hands for only 12 seconds. On 3/1/16 at 4:20 P.M., an interview was	F 441		

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F 441	Continued From page 103 conducted with LPN B. When asked about the importance of wearing a disposable gown, and why she didn't wear one, LPN B stated, "She has MRSA in her heel. Since I'm not messing with the wound itself, I didn't put it on. Handwashing is important to prevent infection from me or them. Handwashing should be for 30 seconds. I use the birthday song. I don't know why I didn't use the song, just a little bit of nerves." On 3/1/16 a review was conducted of facility documentation, revealing a Handwashing/Hand Hygiene Policy dated August 2014. It read,"This facility considers hand hygiene the primary means to prevent the spread of infections. Wash hands with soap and water for the following situations: After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. Vigorously lather hands with soap and rub them together, creating friction to all surfaces for a minimum of 20 seconds or longer under a moderate stream of running water, at a comfortable temperature." On 3/2/16 at 4:00 P.M. the facility Director of Nursing (Administration B) was notified of the findings. No further information was received.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 456	**F 456** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The Crash Cart on Unit 1 had the Oxygen tank replaced with a full Oxygen tank and the Unit 2 Crash Cart had suction catheters placed on it on 03/03/16. Resident #1 feeding pump pole was cleaned on 03/03/16 **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents had the potential to be affected	

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F 456	Continued From page 104 Based on observation, staff interview and facility documentation review, the facility staff failed to ensure essential equipment was clean and functional for Resident #1 and Resident #2, for two medication carts and two crash carts. 1. On unit One, the oxygen tank was empty on the crash cart. On Unit two, the crash cart did not have suction catheters available. 2. For Resident #1, the facility staff failed to ensure her gastrostomy pump pole was clean and failed to ensure medication carts on both units were clean; 3. For Resident # 27, the facility staff failed to maintain a clean tube feeding pole. The findings included: 1. On unit One, the oxygen tank was empty on the crash cart. On Unit two, the crash cart did not have suction catheters available. On 3/3/16 at 3:25 PM, the crash cart on unit one was observed. The oxygen tank on the crash cart was determined to be empty. LPN (licensed practical nurse) D stated, "The night shift checks the crash cart." The crash cart sign off sheet was reviewed, which showed for the previous night, the oxygen tank was signed off as full. LPN (D) was asked if the crash cart had been used last night or during the current day, and she stated, "No." The nurse was observed to be replacing the oxygen tank. On 3/3/16 at approximately 3:30 PM, the crash cart on unit two was checked. No suction catheters were available for emergency use. The	F 456	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Housekeeping will be in-serviced by the Executive Director or Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor by 04/01/16 on the cleaning of poles and other equipment and surfaces in resident rooms. The Field Services Clinical Director will educate the Director of Nursing Services on monitoring to ensure crash carts are restocked and full oxygen tanks are on carts. Licenses Nursing Staff will be in-serviced by Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor on replacing items that are not found on the crash carts from the checklist. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits of the crash carts will be conducted by the Director of Nursing or Assistant Director of Nursing or Nurse Supervisors 3 times per week for 3 months to ensure all equipment and items are present. Results of the audits will be presented in QAPI for discussion and follow up/action. Audits of rooms with feeding pump poles will be checked via the non clinical round 3 times per week for 3 months by the Executive Director or Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor. Findings of the audits will be discussed and reviewed in the monthly QAPI for follow up and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is April 4, 2016	

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F 456	Continued From page 105 crash cart check list was observed, which showed the nurse had signed off suction catheters were on the crash cart. On 3/3/16 at 4:15 PM, the Administrator and nurse consultant were notified of above findings. 2. For Resident #1, the facility staff failed to ensure her gastrostomy pump pole was clean and failed to ensure medication carts on both units were clean. Resident #1, a female, was admitted to the facility 6/13/13. Her diagnoses included sacral pressure ulcer, aphasia, contracture, Alzheimer's dementia, and hypertension. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/28/15 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total assistance of one to two staff members to perform her activities of daily living. She was coded as receiving all nutrition and hydration by a gastrostomy tube. A gastrostomy tube is a flexible tube surgically inserted though the abdominal wall into the stomach. The tube is utilized to administer hydration, nutrition, and medications to Residents who are unable to swallow. Resident #1 was observed 3/1/16 during initial tour of the facility, 3/1/16 at 5:06 p.m., 3/2/16 at 8 a.m., 3/2/16 at 8:45 a.m., and 3/3/16 at 8:02 a.m. At all observations, Resident #1 was lying on her back or side with the head of her bed elevated. Her eyes were closed and her gastrostomy tube	F 456		

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F 456	Continued From page 106 was infusing at 35 cc (cubic centimeters) an hour. Jevity 1.5 was infusing through a gastrostomy pump. At all of the observations, the base of the pole, holding the pump, was covered with dried light brown substance. Some of the dried substance was also on the floor under the pole stand. When interviewed, RN (registered nurse) A stated it was housekeeping's responsibility to keep the pump poles clean, 3/4/16 at 12:15 p.m. During observation of the medication rooms and carts, 3/3/16 beginning at 10:40 a.m., the medication carts on Unit 1 were observed. The tops of both carts were covered with fine white debris. The sides and fronts of the carts had dried droplet substances on them, including the areas that held the plastic medication and drink cups. On Unit 2, the medication carts were observed beginning at 10:48 on 3/3/16. The #2 cart had the same white debris on the of the cart. When interviewed, ADM C stated 3/4/16 at 12:15 p.m., she was uncertain as to when the medication carts should be cleaned. She did say she thought the nurses should clean the carts prior to beginning their medication pass. The acting administrator, ADON (acting director of nursing), and corporate consultant were informed of the failure of the staff to ensure Resident #1's gastrostomy pump pole, the medication carts on unit 1, and medication cart 2 on unit 2 were clean, 3/4/16 at 12:15 p.m. 3. For Resident # 27, the facility staff failed to maintain a clean tube feeding pole.	F 456		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 456	Continued From page 107 Resident # 27 was a 60 year old female admitted to the facility on 2/18/2012 with the diagnoses of, but not limited to, Type 1 Diabetes Mellitus, Stroke, Hemiplegia and Hemiparesis, Aphasia, Gastrostomy, Major Depressive Disorder, Single Episode, Hypertension, Gastroesophageal Reflux Disease (GERD), and Cataract. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/19/2016. The MDS coded Resident # 27 with cognitive status as moderately impaired; required extensive assistance of one to two staff members with activities of daily living and always incontinent of bowel and bladder. On 3/3/2016 at 11:30 AM, observed the base of the pole holding the tube feeding was soiled with dried yellowish debris in three areas. On 3/3/2016 at 11:50 AM, observed Housekeeping staff enter the room of Resident # 27 and clean the area around the bed by the door. Resident # 27 was in the bed by the window and her husband was talking to the surveyor at the time Housekeeping staff (Other N) was in the room. Resident # 27's husband spoke to Other N and stated to the surveyor that Other N was "good and does a good job." On 3/3/2016 at 12 noon, an interview was conducted with Housekeeping staff (Other N) who stated "out of respect for the residents, we don't clean the rooms when visitors are there. We come back when we can. " On 3/3/2016 at 2:30 PM, Other N was observed	F 456		

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F 456	Continued From page 108 cleaning Resident # 27's side of the room while the resident's husband was out of the room. One plastic cap that fit on tube feeding tube and one tissue were removed from under Resident # 27's bed. An interview was conducted with RN B on 3/3/2016 at 3 PM. RN B went to Resident # 27's room with the surveyor and looked at the base of the tube feeding pole. RN B stated "it is dirty" and stated she was going to make sure it was cleaned. RN B stated it was the responsibility of the nursing department to clean the tube feeding poles. The administrator and Corporate Consultants were informed of the soiled base of the tube feeding pole during the end of day debriefing on 3/3/2016. No dirt or debris was observed in Resident # 27's room on 3/4/2016 at 8:15 AM. The tube feeding pole was observed to be clean and without debris. On 3/4/2016 at 8:30 AM, an interview was conducted with RN B who stated she had the nursing staff change the tube feeding pole. RN B stated she instructed the nursing staff to clean any spills of tube feeding at the time of the spill. An interview was conducted on 3/4/2016 at 10:30 AM with the Housekeeping Director (Other J) who stated "terminal cleaning is done in all of the rooms on a schedule of 1-3 rooms per day. Other J stated that routine cleaning is done daily in all of the rooms. The corporate consultant presented a copy of the	F 456		

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F 456	Continued From page 109 Housekeeping policy on "Daily Patient Room Cleaning" dated 1/1/2000 which stated the staff should follow a 5 step room cleaning method: 1)empty trash, 2) horizontal dusting, 3)spot clean, 4) dust mop floor and 5) damp mop floor. No further information was presented. COMPLAINT DEFICIENCY	F 456	**F 514** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 12 face sheet was verified and corrected on 03/02/16 **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure an accurate medical record. For Resident # 12, the facility staff had inaccurate information on the face sheet. Under Convicted of a Sexual Offense, the facility answered "yes" and there was no record of conviction of a sexual offense for Resident # 12.	F 514	The Admission Director and or Admissions Assistant or Medical Records will conduct a audit of current resident face sheets to ensure that there are none with inaccurate Sexual Offense information by 04/01/16 **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Admissions, Social Services, Medical Records will be in-serviced by the Executive Director on ensuring the accuracy of information on the Residents face sheets by 04/01/16 which will include Sex Offender status. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Residents face sheet will be reviewed for accuracy upon admission and quarterly by the Social Worker, or Social Worker Assistant, or Admissions Director or Admissions Assistant and findings will be reported in QAPI monthly for review and action steps. **5.) Date Corrective Action will be completed.** April 4, 2016	

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F 514	Continued From page 110 Findings included: Resident # 12, a 69 year old female, was admitted to the facility 12/8/2014. Her diagnoses included but not limited to Psychosis, Diabetes, Morbid Obesity, Major Depressive Disorder, Anxiety, Hypertension and history of Intestinal Obstruction. Resident # 12's most recent MDS with an ARD of 2/1/2016 was coded as a quarterly assessment. Resident # 12's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 12 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident # 12 was coded as needing only limited assistance. Resident #12 was coded as always incontinent of bowel and bladder. Resident #12 was coded as being able to hear, speak, understand, and be understood. Review of the clinical record was conducted on 3/1/2016 and 3/2/2016. Review of the Face Sheet printed on 10/16/2015 and located in the front of the clinical record revealed under "Other Information" that the question Convicted of a sexual offense was answered as "yes". 3/2/3016 at 4 PM, an interview was conducted with Unit Manager (LPN G Licensed Practical Nurse G) who stated she did not think Resident #	F 514		

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F 514	Continued From page 111 12 was a convicted sex offender. LPN G reviewed the face sheet and stated she was going to double check with the Social Services Director and Admissions Coordinator. LPN G stated she had not noticed the "yes" answer under convicted of a sexual offense but thought it was a mistake. LPN G stated she usually used the face sheet to look for the demographics, physicians, pharmacy and responsible party and insurance information. Interview was conducted with Social Services Director (Other D) on 3/2/2016 at 4:30 PM who stated she was told by the Unit Manager (LPN G-Licensed Practical Nurse G) that the face sheet showed "yes" for Sexual Offender status. Other D stated she asked the Admission Coordinator (Other F) to rerun the Sex Offender Registry for Resident # 12. Other F stated Resident # 12 was not listed as a known sex offender. 3/2/2016 at 4:35 PM, interview conducted with Admission Coordinator (Other F) who stated she ran the Sex Offender Registry Search and it showed that Resident # 12 was not on the list. Other F stated the wrong button was clicked when the face sheet was typed because Resident # 12 was not a convicted sex offender. Other F stated she was going to run a corrected copy of the face sheet. The Administrator, Director of Nursing and Corporate Consultant (Admin C) were informed of the answer of "yes" for Convicted of a sexual offense on the face sheet of Resident # 12 during the end of day debriefing on 3/2/2016 at approximately 5 PM.	F 514		

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F 514	Continued From page 112 No further information was provided.	F 514		

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F 309	Continued From page 55 every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift Catheter care every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift silver absorbing dressing twice daily and cover with foam dressing: 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift 18 Indwelling Foley catheter with 10 cc (cubic centimeter) bulb secured with anchor every shift: 1/5/16 evening shift, 1/23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift. 2/8/16 day shift Abdominal binder at all times every shift: 1/5/16 evening shift, /23/16 day shift, 1/24/16 day shift, 1/29/16 day shift, 2/4/16 day shift, 2/8/16 day shift Apply foam dressing to sheer wound of the coccyx: 1/23/16, 1/24/16, 1/29/16, 2/24/16 Selsun Blue shampoo three times weekly: 1/29/16 Valid physician's orders were evident for the treatments in question. Review of the clinical record revealed no evidence Resident #1 refused the treatments in question, nor that she was out of the facility. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "Documentation:	F 309		

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F 309	Continued From page 56 1). The individual who administers the medication dose records the administration on the resident's MAR (medication administration record) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administer the medications report off-duty without first recording the administration of any medications. " When interviewed, RN (registered nurse) B stated 3/2/16 at 3:15 p.m., the administration of treatments followed the same standards as medications and should be documented as having been administered. After reviewing the documentation for the treatments, RN B stated the treatment nurse traditionally did all the treatments in the facility and was responsible for documenting them. RN B said on the days in question, the treatment nurse had to pass medications and that each nurse would have been responsible for their treatments. RN B stated she did not know if the treatments had been done, however she did not think they had been administered on the days in question. Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of	F 309		

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F 309	Continued From page 57 medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." The acting administrator, ADON (assistant director of nursing), and corporate consultant were informed of the failure of the staff to administer the treatments indicated to Resident #1 per physician's orders, 3/4/16 at 12:15 p.m. 3. For Resident #8, the facility staff failed to ensure treatments were administered as ordered by the physician. Resident #8, a female, was initially admitted to the facility 9/10/08 and readmitted after a hospitalization 8/4/10. Her diagnoses included hypothyroidism, dementia, major depressive disorder, unspecified psychosis, anxiety disorder, hypertension, arteriosclerotic cardiovascular disease, and gastroesophageal reflux disease. Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/24/15 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required extensive to total assistance of one staff member to perform her activities of daily living. Review of Resident #8's clinical record revealed no evidence the following treatments were administered on the days listed:	F 309		

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F 309	Continued From page 58 Chair alarm every day and evening shift: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift assist side rails on bed to assist with positioning and mobility every shift: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Bed alarm: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Geri sleeves every shift to bilateral arms: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Pads to arms of wheelchair at all times: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Remove lap buddy from wheelchair for 10 min every 1 hr (hour) and @ meal times: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Wander guard continuous every shift: 2/4/16 on day shift, 2/8/16 day shift, 2/28/16 day shift Valid physician's orders were evident for the treatments not documented as having been administered. Review of the clinical record revealed no evidence Resident #8 had refused the treatments or was out of the building during the time the treatments would have been administered. When interviewed, RN (registered nurse) B stated 3/2/16 at 3:15 p.m., the administration of treatments followed the same standards as medications and should be documented as having been administered. After reviewing the documentation for the treatments, RN B stated the treatment nurse traditionally did all the treatments in the facility and was responsible for	F 309		

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F 309	Continued From page 59 documenting them. RN B said on the days in question, the treatment nurse had to pass medications and that each nurse would have been responsible for the treatments. RN B stated she did not know if the treatments had been done, however she did not think they had been administered on the days in question. The acting administrator, ADON, and corporate consultant were informed of the failure of the staff to administer the treatments indicated to Resident #8 per physician's orders, 3/4/16 at 12:15 p.m. 4. For Resident #17, the facility staff failed to administer medications and treatments as ordered by the physician. Resident #17, a female, was initially admitted to the facility 4/1/10 and readmitted after a hospitalization 4/29/14. Her diagnoses included seizures, type II diabetes mellitus, cataract, depression, constipation, hyperlipidemia, peripheral vascular disease, gastroesophageal reflux disease, and hypertension. Resident #17's most recent MDS with an ARD of 2/18/16 was coded as a quarterly assessment. Resident #17 was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing limited to extensive assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing she was coded as requiring total assistance of one staff member. Review of Resident #17's clinical record revealed no evidence the following medication and treatments were administered:	F 309		

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F 309	Continued From page 60 Monitor blood pressure and pulse q (every) week: No pulses were obtained for the following weeks 1/7/16, 1/14/16, 1/21/16, 1/28/16, 2/4/16, 2/11/16, 2/18/16. and 2/25/16 Tylenol 8 hour extended release 650 1 tablet every 8 hours: 2/21/16 at 2 p.m., 2/26/16 at 2 p.m. Gold Bond cream every shift to abdominal folds: 2/14/15 on evening and night shift Sure prep to first metatarsal on right foot every shift: 2/1/4/16 on evening and night shift When interviewed, RN B stated 3/3/16 at 2:18 p.m., the nurse that entered the order for blood pressure and pulse to be obtained weekly in the computer, did not put the order in correctly. No area was entered for the pulse to be documented, therefore the nurse did not obtain the pulse. RN B was unable to determine if the medications and treatments had been administered or were not administered. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "Administration 2). Medications are administered in accordance with written orders of the prescriber. Documentation: 3). The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials	F 309		

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F 309	Continued From page 61	F 309		

on each MAR are cross referenced to a full signature in the space provided or on an applicable signature log."

The acting administrator, ADON (assistant director of nursing, and corporate consultant were informed of the failure of the staff to administer medications and treatments as indicated to Resident #17 per physician's orders, 3/4/16 at 12:15 p.m.

5. For Resident #20, the facility staff failed to administer medications and treatments as ordered by the physician.

Resident #20, a female, was admitted to the facility 11/1/13. Her diagnoses included Parkinson's, anxiety, chronic obstructive pulmonary disease, anemia, hyperlipidemia, cerebral pseudo sclerosis, epidemic vertigo, dementia, unspecified psychosis, paranoid delusions, osteoarthritis, and congestive heart failure.

Resident #20's most recent MDS with an ARD of 12/1/15 was coded as a quarterly assessment. Resident #20 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #20 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, Resident #20 was coded as requiring standby assistance of one staff member.

Review of Resident #20's clinical record revealed no evidence the following medications and treatments were administered:

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F 309	Continued From page 62 Greers goo apply to buttocks q (every) shift and as needed: 1/15/16 on evening shift, 1/31/16 night shift, 2/14/16 on evening and night shift MA 65 air mattress every shift: 1/15/16 on evening shift, 1/31/16 night shift, 2/14/16 on evening and night shift Monitor sutures to right thigh: 1/15/16 on evening shift, 1/31/6 night shift, 2/14/16 on evening and night shift FerrouSul tablet 325 mg (milligram) by mouth three times a day: 2/21/16 1 p.m., 2/26/16 1 p.m. A valid physician's order was evident for all the medications and treatments in question. Review of the clinical record revealed no evidence Resident was out of the facility or had refused the medication or treatments in question. Prior to the end of the survey, no evidence was presented to determine if the medications and treatments were not administered or if they were administered and not documented. The acting administrator, ADON, and corporate consultant were informed of the failure of the staff to administer medications and treatments as indicated to Resident #20 per physician's orders, 3/4/16 at 12:15 p.m. 6. For Resident #28, the facility staff failed to administer treatments as ordered by the physician. Resident #28, a female, was admitted to the facility 2/4/13. Her diagnoses included legally blind, anemia, atrial fibrillation, type II diabetes	F 309		

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F 309	Continued From page 63 mellitus, chronic renal failure, chronic obstructive pulmonary disease, hyperlipidemia, peripheral vascular disease, congestive heart failure, transient ischemic attack, and hypertension. Resident #28's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/6/16 was coded as a quarterly assessment. Resident #28 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #28 was coded as needing minimal to stand by assistance of one staff member with her activities of daily living with the exception of bathing. For bathing, she was coded as requiring total assistance of one staff member. Review of Resident #28's clinical record revealed no evidence the following treatments were administered per physician's orders: Barrier cream every day: 1/23/16, 1/24/16, 1/29/16 A thorough review of the clinical record revealed no indication that Resident #28 refused the treatment or was not at the facility on the days in question. A valid physician's order was evident for the treatment. The acting administrator, ADON, and corporate consultant were informed of the failure of the staff to administer barrier cream daily on 1/23. 1/24. and 1/29/16, 3/4/16 at 12:15 p.m. 7. For Resident #4, the facility failed to document medications, including an antibiotic.	F 309		

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F 309	Continued From page 64 Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The most recent MDS (minimum data set) dated 2/3/16 did not code the resident's BIMS (brief interview of mental status) score nor had his cognitive status been assessed, but contained only dashes. The previous MDS had coded the BIMS score as "7" out of a possible 15 or moderate cognitive impairment. The MDS coded the resident as requiring total assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. Review of the MAR (medication administration record) for February 2016 revealed several medications not documented as given. These are the omissions: 2/6/16: 2:00 PM- Humalog 3 units subcutaneously every 8 hrs 2/21/16: 12:00 PM- Clindamycin (antibiotic)150 mg (milligrams) every 6 hours for pneumonia 2/21/16: 12:00 PM- Duoneb (nebulized bronchodilator) one every 6 hours for pneumonia 2/6/16: 1:00 PM- Ferrous sulfate 325 mg (iron supplement) one tablet three times daily 2/21/16: 1:00 PM- Ferrous sulfate- 7.5 cc (cubic centimeters) three times daily 2/21/16: 2:00 PM- Seroquel (antipsychotic) 25 mg every 8 hours 2/6/16: 1:00 PM- Seroquel 50 mg three times daily On 3/2/16 at 5:00 PM, the Administrator and DON (director of nursing) were notified of above findings. The DON stated, "The medications should be signed when given."	F 309		

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F 309	Continued From page 65 8. For Resident #2, the facility staff failed to perform treatments as ordered by the physician. Resident # 2 was admitted to the facility on 10/7/13 and readmitted after a hospitalization on 1/14/16. Her diagnoses included, but not limited to, diabetes, anemia, hypertension, heart disease, peripheral vascular disease, and aphasia (a communication disorder) The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/21/16. The MDS coded Resident # 2 with cognitive status as severely impaired; required total assistance with activities of daily living (ADLs) and always incontinent of bowel and as having an indwelling catheter for bladder elimination. Resident #2 was coded as receiving nutrition by way of a feeding tube and for having a Stage IV pressure ulcer. The MDS describes as Stage IV pressure ulcer as follows, "Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed.) Review of Resident #2's clinical record revealed no evidence that the following treatments were administered: "Medihoney Wound/Burn Dressing Gel. Apply to Right Middle Shin topically every day shift for open area. Clean with NS (normal Saline) and apply Medihoney and cover with dry dressing - 1/23, 1/24, 1/29/16. Santyl Ointment 250 unit/gm (gram), Apply to sacrum topically every day shift for sacral wound.	F 309		

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F 309	Continued From page 66 Clean with NS and cover with alldress - 1/23, 1/29/16. Barrier Cream to bilateral buttocks q (every) shift for excoriation- 1/5/16, evening shift. Heel lift boot to left foot every shift for prevention - 1/5/16 evening shift. Monitor wound vac every shift for pressure ulcer - 1/5/16 evening shift. Silver Absorbent Dressing to right middle shin - 1/5/16 evening shift. Wound Vac continuous every shift for pressure ulcer - 1/5/16, evening shift." A valid physician's order was evident for the treatments in question. On 3/2/16 at 5:00 p.m., the director of nursing was informed of the treatments that were not documented as having been administered. The facility cited Lippincott as their reference for professional standards. On 3/4/16, at 2:15 p.m., the administrator and corporate consultants were informed of the failure of the staff to ensure treatments were documented as performed per physician's orders for Resident #2. 9. For Resident # 16, the facility staff failed to clarify an order for Accu Check blood sugar to include parameters and did not notify the physician of elevated blood sugar results of 562 on 2/25/2016.	F 309		

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F 309	Continued From page 67 Resident # 16 was an 80 year old female admitted to the facility on 7/19/2015 and readmitted on 1/13/2016 with the diagnoses of, but not limited to, Congestive Heart Failure, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Hypertension, Diabetes, Dysphagia, End Stage Renal Disease, Anxiety, Gastrointestinal Hemorrhage, and Dyspnea. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/30/2015. The MDS coded Resident # 16 with a Brief Interview for Mental Status (BIMS) of 4 out of 15 indicating severe cognitive impairment; required extensive assistance of one staff member with activities of daily living and always incontinent of bowel and bladder. Clinical record review was conducted on 3/2/2016. Review of the February 2016 MAR (Medication Administration Record) revealed an order for Accu-Chek before meals and at bedtime order date 2/2/2016. Review of blood sugar results revealed a blood sugar of 562 on 2/25/2016 at 9 PM. Review of the Physicians Order Summary signed by the physician on 2/9/2016 showed an order for "Accu-Chek Active Strip (Glucose Blood) 1 application in vitro before meals and at bedtime related to Type 2 Diabetes Mellitus without complications" order date 1/13/2016. Review of the Nurses Notes revealed no documentation of physician being notified of	F 309		

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F 309	Continued From page 68 elevated blood sugar. During the end of day debriefing on 3/2/2016, the Administrator, Director of Nursing and Corporate Consultant (Admin C) were informed of elevated blood sugar of 562 and no parameters on the order for Accu-Check before meals and at bedtime. The Corporate Consultant stated she would check the corporate policy to be sure but thought it was that the physician should be notified if blood sugars were less than 60 or greater than 400. On 3/3/2016 at 10 AM, an interview was conducted with the Unit Manager LPN G (Licensed Practical Nurse) G who stated there were no parameters listed on the order for Accu-Chek blood sugars. LPN G stated "the nurse should have called on a blood sugar of 562, as a nursing judgment." LPN G stated she was "going to call the doctor today." Further review of the February 2015 MAR showed two more blood sugars greater than 400. Blood Sugar was 448 on 2/14/2016 at 9 PM and Blood Sugar of 406 on 2/20/2016 at 10:30 AM. On 3/4/2016 at 8:15 AM, LPN G presented a copy of the Progress Note dated 3/3/2016 at 4:32 PM which stated the doctor "made aware of blood glucose on 2/25/2016 562 and parameters needed." New orders "received to notify the doctor if blood glucose is less than 60 or greater than 450. Will continue to monitor." LPN G also presented copies of the Physician's Pharmacy Order form to discontinue the previous Accu-Check order and the Pharmacy form with the new order of Accu-Check with parameters ordered 3/3/2016.	F 309		

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F 309	Continued From page 69 Corporate Consultant (Admin C) presented a copy of the facility's Diabetes Management Guideline, Version # 5. On page 4 of 7 under Monitoring/Compliance, stated: "The following elements are in place for the center to demonstrate satisfactory compliance with the guide: Residents with a diagnosis of Diabetes have an order for Blood Glucose monitoring, MD (medical doctor) notification parameters in place, Glucose gel is used for hypoglycemic events." On page 6 of 7, Acute Management: Diabetic Resident under caption Hyperglycemia stated to "inform physician as directed by parameters for one occurrence...." And, at the bottom of page 6 stated "Notify physician as directed by blood glucose." No further information was provided.	F 309		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure	F 313	RECEIVED APR 0 1 2016 VDH/OLC F 313 **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident # 4 had new glasses ordered and they were received and given to the resident on 03/22/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents with assistive vision devices have the ability to be affected and an audit will be conducted by the Social Worker or Social Worker Assistant of those residents to ensure that their assistive vision devices are available to them. Audit will be conducted by 04/01/16.	